BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

Authorization for Disclosure of Mental Health Clinical Information

This authorization will permit Physicians providing mental health services to Blue Cross and Blue Shield of Alabama Members to disclose your mental health clinical information that you describe below ("Mental Health Clinical Information") to Blue Cross and Blue Shield of Alabama and its business associate(s) on behalf of your Health Plan and for the purpose that you describe below. This authorization is not required by Federal Law or your Group Health Plan, but may be utilized by Physicians in their practice.

A. The Individual Who is The Subject of The Mental Health Clinical Information.

Name	Date of Birth *(MMDDYYYY)*	Contract Number (as it appears on your Health Plan ID Card)	Social Security Number
Address			Telephone Number [ ] –

B. Description of My Mental Health Clinical Information To Be Disclosed.

Note: Please insert your initials in front of the paragraph below (1, 2 or 3) that applies to the description of your Mental Health Clinical Information to be disclosed pursuant to this authorization. If you initial paragraph 2 or 3, please complete the blanks below that paragraph.

1. ________ Any or all of my Mental Health Clinical Information that may be requested from time to time by Blue Cross and Blue Shield of Alabama

2. ________ All my Mental Health Clinical Information related to one or more of the following:

Description of Claim ____________________

Timeframe(s) of Service ____________________

Name of Provider ____________________

3. ________ Other. Here is a specific description of my Mental Health Clinical Information to be disclosed.

____

____

C. Company Authorized To Receive My Mental Health Clinical Information.

By signing this authorization, I hereby authorize Blue Cross and Blue Shield of Alabama and its business associate(s) on behalf of my Health Plan (identified by the Contract Number above) to receive my Mental Health Clinical Information.

D. Physician Authorized To Disclose My Mental Health Clinical Information.

Physician's Name ____________________

Physician's Address ____________________

Physician's Telephone [ ] – ____________________

E. Purpose of This Disclosure of My Mental Health Clinical Information.

☐ At my request ☐ Other (please specify) ____________________

F. Date of Expiration of this Authorization.

Expiration Date ____________________

If no expiration date is indicated, this authorization will expire in 90 days from the date of this authorization.

(continue on back)

G. Right to Revoke this Authorization.

I understand that I may revoke this authorization at any time by giving written notice of my revocation to the address of the Physician listed in Section D. I understand that revocation of this authorization will not affect any action taken in reliance on this authorization before my written notice of revocation was received.

H. Signature:

I, ____ , have had full opportunity to read and consider the contents of this authorization.

Signature ____ Date ____________________

*Personal Representative Signature ____ Date ____________________

*If signed as a Personal Representative, you must describe your authority to act as the Personal Representative of the individual who is the subject of the Protected Health Information described in this authorization (”Individual”) by initialing one of the following:

_____________ The Individual is an unemancipated minor child, I am the parent and have authority under applicable law to act on behalf of the Individual in making decisions related to health care, and the health information described herein is relevant to my personal representation of the Individual. ***Please Note: You should consult your state’s laws to find out if you have legal authority to make health care decisions for your child. If you are unsure whether you have such legal authority, both you and your child must sign this authorization.***

_____________ The Individual is an adult, unemancipated minor or emancipated minor, I am the guardian, attorney-in-fact or other authorized representative and have authority under aplicable law to act on behalf of the Individual in making decisions related to health care, and the health information described herein is relevant to my personal representation of the Individual. ***Attached is a copy of the legal document(s) that give me authority to act as a Personal Representative, such as letters of guardianship.***

_____________ The Individual is deceased, I am the executor, administrator or other person authorized under applicable law to act on behalf of the Individual’s estate, and the health information described herein is relevant to my personal representation of the Individual or the Indivudual’s estate. ***Attached is a copy of the legal document(s) that give me authority to act as a Personal Representative, such as letters testamentary or letters of administration.***

PLEASE RETAIN A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS AFTER YOU SIGN IT.