



MASSACHUSETTS Permission for One-Time Disclosure of Information

Use this form to grant Blue Cross Blue Shield of Massachusetts (Blue Cross) permission to make a single disclosure of specific information to a specific person when that disclosure is not otherwise allowed by law. Use of this form does not provide the recipient with unlimited access to the member's Information, nor does it authorize the recipient to represent the member in health care issues. If you wish to designate an authorized representative to assist you with a health care issue, please use the Member's Designation of an Authorized Representative Form. If you want to identify a legal representative, then use the Documentation of Legal Representative Status Form.

The member named below should be the person signing this authorization and requesting the release of information. If the member is a minor, a parent or legal guardian must sign. If the member is unable to sign for any other reason, a legal representative must sign the authorization and submit documentation to verify the authority to sign.

A. MEMBER INFORMATION

Member's name (please print): _____
Member's ID#: _____ Member's date of birth: _____
Address: _____
Phone number: _____

B. INFORMATION TO BE DISCLOSED TO THIRD PARTY

All my information. This may include a *diagnosis* (name of illness or condition), *procedure* (type of treatment), *names of doctors and other health care providers*. **This does not include sensitive information (see below), unless expressly approved below.**

If "all my information" is not checked above, I authorize Blue Cross to disclose **only the following specific information, excluding sensitive information (unless approved below):** (check all boxes that apply and indicate time frame)

- Appeals
- Benefits and coverage
- Billing
- Claims and payment
- Dental
- Diagnosis and procedure
- Eligibility and enrollment
- Medical records
- Pharmacy
- Other (please describe) _____

Sensitive information. I approve the disclosure of the following types of sensitive information by Blue Cross: (check all boxes that apply and indicate timeframe)

- HIV or AIDS
- Mental or behavioral health
- Alcohol and substance abuse

For the following timeframe (example: 01/09/2017 to 01/30/2017) from: _____ to: _____

C. NAME AND ADDRESS OF THIRD PARTY TO WHOM INFORMATION IS BEING DISCLOSED

Name of person or entity to receive information: _____
Address: _____

D. DATE YOUR AUTHORIZATION EXPIRES

This authorization expires once Blue Cross makes the disclosure requested above.

E. MEMBER (OR LEGAL REPRESENTATIVE) SIGNATURE AND DATE

I have read the contents of this form. I agree and allow Blue Cross to disclose my information as I have requested above. I understand that Blue Cross does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or eligibility benefits, except as may be permitted by the Health Insurance Portability and Accountability Act (HIPAA). I understand I am entitled to a copy of this form and agree that a photocopy is as valid as the original. I understand this designation is valid until I revoke it or it expires as described in Part D above. I may revoke this designation at any time by notifying Blue Cross in writing at the address provided below. I understand that a revocation will not apply to information that was already disclosed. I understand that once information has been disclosed according to these instructions, the HIPAA Privacy Rule and other privacy laws may no longer protect the information.

Signature: _____ Print Name: _____

Today's Date: _____

If not the member, please state your relationship to the member (for example, "parent") here: _____

Questions about this form should be directed to the Member Service department at the phone number listed on the front of your member ID card.

Mail or fax this completed form to:

- Blue Cross Blue Shield of Massachusetts, Member Service Correspondence, P.O. Box 9134, N. Quincy, MA 02171-9134
- Fax: 1-617-246-3674

Please keep a copy of this form for your records.

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: 711).

Spanish/Español: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

Portuguese/Português: ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).