WYOMING

An independent licensee of the Blue Cross and Blue Shield Association

HIPAA Authorization to Release Information

This form is to be used by health plan participants age 18 and older to authorize Blue Cross Blue Shield of Wyoming and/or FlexShare Benefits to use and/or disclose participant's protected health information for the purposes stated by participant herein.

Section A: Participant information (Please type or print clearly)

Participant name: _____ Birth date: _____

Address: _____

City: _____ State: _____ Zip: _____

Day Telephone: _____ Policy Number or SSN: _____

Section B: The purpose of this authorization

The purpose of this authorization is to give Blue Cross Blue Shield of Wyoming and/or FlexShare Benefits authority to use and/or disclose protected health information regarding my medical, dental, vision, FSA, and/or HRA claims, enrollment and reimbursements as I have specifically designated in Sections C and D below.

Section C: Information to be used and/or disclosed/Restrictions and limitations*

Pursuant to my designations in Section D, I authorize Blue Cross Blue Shield of Wyoming and/or FlexShare Benefits to use and/or disclose my protected health information. I have specifically listed below all protected health information that I ***do not*** want used and/or disclosed, or any other specific limitations on the use or disclosure of my protected health information that I may have. I understand that unless I have specifically excluded or limited the protected health information that may be used and/or disclosed, Blue Cross Blue Shield of Wyoming and/or FlexShare Benefits may use and/or disclose all of my protected health information in their possession, which may include protected health information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about contraceptives, prenatal care, termination of pregnancy, behavioral or mental health services and treatment for alcohol and drug abuse.

(Please describe in as much detail as possible any specific restrictions or limitations on the use and/or disclosure of this information that you may have. For example, if you want this authorization limited to a particular claim, you should include the type of claim, date of service, and name of the provider.

Restrictions or limitations on use or disclosure: _____

_____

_____

*This form may ***not*** be used as an authorization for the use or disclosure of psychotherapy notes.

Section D: Persons or organizations releasing or receiving the information

Organization(s) authorized to release the information: I authorize both Blue Cross Blue Shield of Wyoming (for any Health, Dental and Vision coverage I may have) and FlexShare Benefits (for any Medical Flexible Spending Account (MEDFAS) and/or Health Reimbursement Account (HRA) I may have) as applicable, to release the protected health information I have designated in Section C above.

Person(s) or Organization(s) authorized to receive the information: I authorize Blue Cross Blue Shield of Wyoming and/or FlexShare Benefits to release my protected health information to the following person(s) or organization(s):

Willis Towers Watson - benefit consultants

_____ _____

_____ _____

Section E: Expiration and revocation

Expiration: This authorization is valid for 24 months from the date of my signature below unless I have checked one of the boxes below indicating a shorter period of time.

☐ Expire on: ____/____/_____ (Any date specified cannot exceed 24 months from the date of this authorization).

☐ On occurrence of the following event (which must relate to the purpose of the use and/or disclosure being authorized):

_____

_____

Revocation: I understand that I have the right to revoke or end this authorization at any time. I understand that in order to revoke this authorization I must do so ***in writing*** to Blue Cross Blue Shield of Wyoming and/or FlexShare Benefits at the address listed below. I understand that my revocation of this authorization will not affect any action that Blue Cross Blue Shield of Wyoming and/or FlexShare Benefits have taken, or any information that Blue Cross Blue Shield of Wyoming and/or FlexShare Benefits have already used or disclosed based upon this authorization before Blue Cross Blue Shield of Wyoming and/or FlexShare Benefits actually received my written request to revoke it.

Section F: Signature/authorization

I have read and understand the contents of this authorization. I have signed this authorization voluntarily and I understand that my enrollment in my health plan and my eligibility for benefits is not conditioned in any way upon me signing this authorization.

I understand that the protected health information described above may be disclosed to and/or received by persons or organizations that are not subject to federal health information privacy laws. These persons or organizations may further disclose the information, and it may no longer be protected by federal health information privacy laws.

By signing this form, I am confirming my authorization for the use and/or disclosure of my protected health information, as described in this form.

Signature:_____ **Date:**_____

Section G: Personal Representative**

If this authorization has been signed by a personal representative on behalf of a participant, please complete the following:

Personal Representative's Name:_____ Relationship to Individual:_____

**Documentation regarding your authority to act as the personal representative for the participant must accompany this form.

UPON REQUEST, YOU ARE ENTITLED TO A COPY OF THIS FORM AFTER YOU SIGN IT.

Please notify us of any changes to the information provided on this form.

Blue Cross Blue Shield of Wyoming
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Fax: 307.634.5742

FlexShare Benefits
Blue Cross Blue Shield of Wyoming
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Phone: 1.888.557.2230 OR 307.432.2788
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