CBA Blue
An independent licensee of the Blue Cross and Blue Shield Association.

Authorization to Release Information (ARI)

SECTION A: The Individual (or the Individual's Personal Representative) confirming the authorization.

I authorize the use and/or disclosure of my protected health information as described in Section B below**.** I understand this authorization is voluntary and made to confirm my direction.

I understand that, if the authorized person(s)/organization(s) authorized in Section B below to receive and/or use the protected health information described below are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose my protected health information and it may no longer be protected by federal health information privacy laws.

I hereby release **CBA Blue** and its subsidiaries, affiliates, employees, officers, agents, and other related entities from any and all liability associated with the release of such information and records to the authorized person(s)/organization(s), and further agree to indemnify, defend and hold **CBA Blue** harmless from any claims relative to this Authorization.

Participant/Member Name | Participant/Member ID #

Participant/Member Address | Participant/Member Date of Birth

SECTION B: Use and/or Disclosure.

☐ By checking here, I understand that my records involving the following Protected Health Information and Sensitive Information shall be used and/or disclosed: general health care, psychotherapy notes (if not previously separated and/or specifically identified by the provider), alcohol and/or chemical dependency, reproductive health (including abortion, pregnancy, contraception, and fertility treatments), communicative diseases (including HIV/AIDS), mental health/psychiatric disorders, and genetic testing.

Entities Authorized to Use or Disclose

Name or specifically identify, the authorized person(s)/organization(s), or the classes of authorized person(s)/organization(s), including **CBA Blue**, who you are authorizing to make use of and/or to disclose the protected health information described above.

**Please Note: you may also want to list others that might need to be authorized such as a pharmacy benefit manager.*

Entities Authorized to Receive and Use Protected Health Information

Name or specifically describe the authorized person(s)/organization(s), or the classes of authorized person(s)/organization(s), to whom you are authorizing **CBA Blue** to disclose and/or let use the protected health information described above. Please provide address and telephone number if known.

Specific purpose for release and how protected health information will be used, if for reason other than general health related matters.

SECTION C: Expiration and Revocation

Expiration
This authorization will expire (please complete one of the below options).

☐ **Date**: _____ (Please enter Month, Day, and Year)

☐ On **occurrence** of the following below event. If related to an event such event must relate to the individual or to the purpose of the use and/or disclosure being authorized. For example, you might choose to have this authorization terminate when coverage terminates.

_____

Right to Revoke
I understand that I may revoke this authorization at any time by giving written notice of my revocation to **CBA Blue**. I understand that my revocation will be effective when **CBA Blue** receives it and that my revocation of this authorization will not affect any action **CBA Blue** took in reliance on this authorization before receiving my written notice of revocation.

SECTION D: Conditioning

Payment, treatment, enrollment, or eligibility for benefits may not be conditioned on the signing of this authorization unless this authorization is for the purposes of the following:

- Research-related treatment
- Determinations relating to underwriting or risk taking prior to enrollment in the health plan
- Creating protected health information solely for disclosure to a third party

SECTION E: Signature

I _____ , have had the full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to **CBA Blue**. I understand that, by signing this form, I am confirming my authorization that **CBA Blue** may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Participant/Member Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the participant/member, please complete the following:

Participant/Member Representative's Name _____

Relationship to Participant/Member giving authority to act as personal representative of individual _____

You are entitled to a copy of this authorization after you sign it. Please return completed form to:

CBA Blue
Attention: ARI/Eligibility
P.O Box 2365
South Burlington, VT 05407-2365
FAX# 802.862.7661