



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):

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.

BCBSWY follows Federal civil rights laws and doesn't discriminate based on race, color, national origin, age, disability or sex. Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-442-2376 (TDD: 1-800-696-4710). 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-442-2376 (TDD : 1-800-696-4710)

**Blue Cross Blue Shield of Wyoming
PO Box 2266
Cheyenne, WY 82003
Phone: 1.800.442.2376
Fax: 307.634.5742**

**FlexShare Benefits
Blue Cross Blue Shield of Wyoming
PO Box 2266
Cheyenne WY 82003
Phone: 1.888.557.2230 OR 1.307.432.2788
Fax: 307.632.1654**



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This Notice is Being Provided as Required by the Affordable Care Act Translation Services

If you, or someone you're helping, has questions about Blue Cross Blue Shield of Wyoming, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 800-442-2376.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue Cross Blue Shield of Wyoming, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 800-442-2376.

如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱 Blue Cross Blue Shield of Wyoming 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字800-442-2376。

Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue Cross Blue Shield of Wyoming haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800-442-2376.

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue Cross Blue Shield of Wyoming, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 800-442-2376.

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue Cross Blue Shield of Wyoming, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 800-442-2376.

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Blue Cross Blue Shield of Wyoming 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 800-442-2376 로 전화하십시오.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue Cross Blue Shield of Wyoming, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 800-442-2376.

Se tu o qualcuno che stai aiutando avete domande su Blue Cross Blue Shield of Wyoming, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 800-442-2376.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue Cross Blue Shield of Wyoming, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 800-442-2376.

Jika Anda, atau seseorang yang Anda tolong, memiliki pertanyaan tentang Blue Cross Blue Shield of Wyoming, Anda berhak untuk mendapatkan pertolongan dan informasi dalam Bahasa Anda tanpa dikenakan biaya. Untuk berbicara dengan seorang penerjemah, hubungi 800-442-2376.

ご本人様、またはお客様の身の回りの方でも、Blue Cross Blue Shield of Wyoming についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、800-442-2376 までお電話ください。

यदि तपाईं आफ्ना लागि आफैँ आवेदनको काम गर्दै, वा कसैलाई मद्दत गर्दै हुनुहुन्छ, Blue Cross Blue Shield of Wyoming बारे प्रश्नहरू छन् भने आफ्नो मातृभाषामा निःशुल्क सहायता वा जानकारी पाउने अधिकार छ। दोभाषे (इन्टरप्रेटर) सँग कुरा गर्नुपरे 800-442-2376 मा फोन गर्नुहोस्।

اگر شما، یا کسی که شما به او کمک میکنید، سوال در مورد Blue Cross Blue Shield of Wyoming، داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. تماس حاصل نمایید. 800-442-2376

જો તમે અથવા તમે કોઇને મદદ કરી રહ્યાં તેમાંથી કોઇને [એસબીએમ કાર્યક્રમનું નામ મુકો] વિશે પ્રશ્નો હોય તો તમને મદદ અને માહિતી મેળવવાનો અધિકાર છે. તે અર્થ વિના તમારી ભાષામાં પ્રાપ્ત કરી શકાય છે. દુભાષિયો વાત કરવા માટે, આ [અહીં દાખલ કરો નંબર] પર કોલ કરો.

Dii kwe'ê atah nilinigiî Blue Cross Blue Shield of Wyoming haada yit'éeego bina'idilkidgo éi doodago háida biká anilyeedigiî t'áadoo le'ê yina'idilkidgo beehaz'áanii hólo' dii t'áa hazaadk'ehji háká a'doowolgo bee haz'á doo báh ilinígóó. Ata' halne'igii koji' bich'í' hodiilniil 800-442-2376.



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Non-Discrimination Notices

Blue Cross Blue Shield of Wyoming (BCBSWY) does not discriminate on the basis of race, color, national origin, sex, age, or disability in its health programs and activities.

BCBSWY provides appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, free of charge and in a timely manner, when such aids and services are necessary to ensure an equal opportunity to participate to individuals with disabilities.

BCBSWY provides language assistance services, including translated documents and oral interpretation, free of charge and in a timely manner, when such services are necessary to provide meaningful access to individuals with limited English proficiency.

In order to obtain the interpretation services listed in paragraphs two (2) and three (3), Participants may call (800) 442-2376 or use BCBSWY's Telecommunications Device for the Deaf (TDD) at (800) 696-4710.

Participants have the right to file a grievance regarding potential discrimination. To file a grievance, please call BCBSWY at (307) 634-1393 or (800) 442-2376 and request the Grievance Officer in the Legal Department or mail a letter describing the grievance to 4000 House Avenue, Cheyenne, WY 82001 to the attention of the Legal Department.

If a Participant believes they have been discriminated against because of their race, color, national origin, disability, age, sex or religion, the Participant may file a discrimination complaint with the Office of Civil Rights. Please visit www.hhs.gov/ocr for directions to file a complaint.