



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 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 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 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 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 Blue Cross Blue Shield of Wyoming, 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 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 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 have taken, or any information that Blue Cross Blue Shield of Wyoming have already used or disclosed based upon this authorization before Blue Cross Blue Shield of Wyoming 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)

Submission instructions: If attaching documentation, please print, sign and mail to the address at right. Otherwise, you may follow the instructions attached to securely upload the form to the message center.

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

Form Submission Instructions

Steps for returning a completed form may depend on whether you obtained the form online, received it by email or through another means. Please read the instructions below to decide which submission method suits you best. If the form specifies a preferred method, please follow those directions instead.

Online: Download the form and fill it out in the free Adobe Reader (get.adobe.com/reader) or fill out the form online if that option exists and then download it to your device. Save the completed form to your computer or device.

Submission:

BY MAIL — Print and mail the completed form to:

Blue Cross Blue Shield of Wyoming, PO Box 2266, Cheyenne, WY 82003.

BY EMAIL — Send the form and any required documentation as attachments to a BCBSWY email address, if one is provided.

BY SECURE UPLOAD — Follow the directions below to securely upload your form at Member.YourWyoBlue.com (member.yourwyoblue.com). Click the link or scan the QR code.

After logging in to your Member.YourWyoBlue.com account:

STEP 1
Click on the **Support** button on the menu bar. Scroll down and select **Send a Message**.

STEP 2
Select the plan the form applies to from the list in the panel. Click **Continue**.

STEP 3
Select General—Other as the **Topic**.

STEP 4
Fill in **Callback Preferences** (*Phone number, *Best time to call, and *May we leave a message...?).

STEP 5
Type any message in the **Message** box.

STEP 6
Click on the paperclip icon next to message box to attach a completed form from its location on your device.

STEP 7
Click on the **Send** button to send your message and upload your saved form securely.

