APPENDIX M

Authorization for Release of Confidential Information under 42 C.F.R. Part 2 – Confidentiality of Alcohol and Drug Abuse Patient Records

Alcohol and/or drug abuse Treatment records cannot be Disclosed without written Consent. This form is used for an Individual to authorize Blue Cross Blue Shield of Wyoming to Disclose the Individual's records that are protected by Federal Confidentiality rules (42 C.F.R. Part 2) to those authorized for the purpose stated below.

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

Please state the purpose of this Authorization below (*the purpose should be narrowly described and should correspond with the information to be released. The purpose should never be as broad as "for all client care"*).

_____

_____

Section C: Information to be Released

The information should be described as exactly and narrowly as possible in light of the purpose of the release (e.g., providers, Treatment dates, types of service, etc.). *Releases for "any and all pertinent information" are not valid.*

_____

_____

The Protected Health Information described above may be Disclosed to and/or received by persons or organizations who are not subject to federal health information privacy laws. These persons or organizations may further Disclose the Protected Health Information, and it may no longer be protected by federal health information privacy laws.

Section D: Persons or organizations releasing or receiving the information

Name or specifically identify the persons and/or organizations (or the classes of persons and/or organizations), whom this Authorization will allow to receive and Use the information described above:

_____ _____

_____ _____

Notice to the Recipient of Information for Alcohol/Substance Abuse Records and Information

This information has been Disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFR Part 2). The federal rules prohibit you from making any further Disclosure of this record unless further Disclosure is expressly permitted by the written Consent of the Individual whose information is being Disclosed in this record or, is otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any Use of the information to investigate or prosecute with regard to a crime any patient with a Substance Use Disorder, except as provided at §§ 2.12(c)(5) and 2.65.

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 may revoke this Authorization at any time by giving oral or written notice of revocation 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 has taken, or any information that Blue Cross Blue Shield of Wyoming has already Used or Disclosed based upon this Authorization before Blue Cross Blue Shield of Wyoming actually received my request to revoke it. I also understand that my revocation may not be effective in preventing release of my information to a Personal Representative, such as a parent or guardian, or person acting in the capacity of a parent or guardian, who applicable law allows to have Access to such health information without my written permission.

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 my alcohol and/or drug abuse Treatment records are protected under federal regulations 42 C.F.R. Part 2 – Confidentiality of Alcohol and Drug Abuse Patient records and cannot be Disclosed without my written Consent.

By signing this form, I am confirming my Authorization for the Disclosure of my alcohol and drug abuse records, 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:_____

Description of Authority**:_____

**Documentation regarding your authority to act as the Personal Representative for the participant must accompany this form (e.g. Power of Attorney, Legal Guardian, etc.).

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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