MASSACHUSETTS

MEMBER'S DESIGNATION OF AN AUTHORIZED REPRESENTATIVE

An *authorized representative* is someone chosen by a member to assist the member with health care issues, and to whom Blue Cross Blue Shield of Massachusetts (Blue Cross) is allowed to disclose and discuss the member's protected health information. An authorized representative is not, however, a person who has legal authority to act on behalf of a member. Use this form to designate an authorized representative to speak to Blue Cross on your behalf and to provide access to your information as shown below. The member should be the person signing this authorization and designating the release of information.

- If the member is a minor, a parent or legal guardian must sign.
- If this form is completed by a legal representative (example: a person who has legal authority to act on the member's behalf), they must complete and submit the Blue Cross Documentation of Legal Representative Status Form prior to submitting this form to Blue Cross.

A. MEMBER INFORMATION

Member's name:
Member's ID#:
Date of birth:
Address:
Phone number:

B. AUTHORIZED REPRESENTATIVE INFORMATION

Name of person:
Address:
Date of birth:
Phone number:

C. INFORMATION THAT BLUE CROSS MAY DISCLOSE

I grant Blue Cross permission to discuss with or disclose to my authorized representative on my behalf:

☐ **All my information.** This may include a diagnosis (name of illness or condition), procedure (type of treatment), claims, doctors and other health care providers, and financial information (like billing and banking). **This does not include sensitive information (see below), unless explicitly approved below.**

✦ If "all my information" is not checked above, I authorize Blue Cross to disclose **only the following specific information, excluding sensitive information (unless approved below).** (check all boxes that apply)

☐ Appeals	☐ Benefits and coverage	☐ Billing
☐ Claims and payment	☐ Dental	☐ Diagnosis and procedure
☐ Eligibility and enrollment	☐ Financial	☐ Medical Records
☐ Pharmacy	☐ Other:	

✦ **Sensitive information.** I approve the disclosure of the following types of sensitive information by Blue Cross (check all boxes that apply):

☐ HIV or AIDS	☐ Mental or behavioral health	☐ Alcohol and substance abuse ***(*Member must designate specific reason for disclosure of this sensitive information.)***

***If alcohol and substance abuse list reason for disclosure:**

☐ to assist with claim(s) payment (including FSA, HRA, HSA, and Coordination of Benefits)

☐ Coordination of care

☐ Assist with treatment

☐ Other (specify): _____

D. DATE YOUR DESIGNATON EXPIRES

This authorization expires *(check one)*:

☐ One-year from date of signature; or

☐ _____ (date to be completed by member/legal rep.; not to exceed 1 year from date of signature)

E. MEMBER (OR LEGAL REPRESENTATIVE) SIGNATURE AND DATE

I have read the contents of this form. I understand, agree, and allow Blue Cross to discuss and/or disclose my information as I have stated above. I understand that Blue Cross does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or eligibility benefits. I understand I am entitled to a copy of this form and agree that a photocopy is as valid as the original.

I understand this designation is valid until I revoke it or it expires as described in Part D above. I may revoke this designation at any time by notifying Blue Cross in writing at the address provided below. I understand that a revocation will not apply to information that was already disclosed. I understand that once information has been disclosed according to these instructions, the Health Insurance Portability and Accountability Act (HIPAA) and other privacy laws may no longer protect the information.

Print name: _____

Signature: _____

Date: _____

If not the member, please state your relationship to the member (for example, "parent") here: _____
Blue Cross may request information, now or in the future, as it deems necessary to confirm authorized representative status.

Questions about this form should be directed to the Member Service department at the phone number listed on the front of your member ID card.

Mail or fax the completed form to:

- Blue Cross Blue Cross Blue Shield of Massachusetts
  Member Service Correspondence
  P.O. Box 9134
  N. Quincy, MA 02171-9134
- Fax: **1-617-246-3674**

Please keep a copy of this form for your records.

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: 711).

Spanish/Español: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

Portuguese/Português: ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).