BlueCross BlueShield | FEP BlueDental

Authorization to Release Information

Please read these instructions carefully before completing the form on page 2

WHEN TO USE THE FORM

- You must complete this form if you want FEP BlueDental to give Protected Health Information (PHI) about you to someone else (for example: your spouse, your daughter or son, or a friend.)
- Please remember that your treating dental provider already has access to your PHI.
- Parents or a legal guardian must sign for a minor.

HOW TO COMPLETE THE FORM

- This Authorization to Release Information form must be *completed* and *signed* by one of the following:
- The member whose PHI will be released; or
- The parent or legal guardian of a minor whose PHI will be released; or
- The Personal Representative of the member whose PHI will be released. *Note: In this instance in addition to the completed form, also send us a copy of the document which appoints the individual to be the Personal Representative of the member whose PHI is to be released: (e.g. power of attorney, conservator, legal guardian, executor).*

TO COMPLETE THE FORM

- Print the first and last name as well as the middle initial of the member whose PHI will be released, as well as his or her date of birth. In addition, also provide the member's ID number which can be found on the ID card of the member noted above. Check the type(s) of information you want us to release.
- Print the first and last name as well as the complete address of the person or organization who will receive the PHI.
- Sign and date the form.
- If you are not the member whose PHI will be released, state your relationship to that person.

MAIL OR FAX THE FORM TO:

Attn: Privacy Officer
FEP BlueDental
PO Box 9304
Minneapolis, MN 55440-9304

Or

Secure Fax # (651)-768-1309

Authorization to Release Information

Member Information (name of individual who is the subject of the data)

Member Name: _____ _____ _____
(First name) (Last Name) (Middle initial)

Date of Birth: _____

Member's 9-Digit ID Number (Located on FEP BlueDental ID card): _____

I authorize FEP BlueDental to release: (check one of the two choices below)

- ☐ Any and All Information Requested
- ☐ Only the following information: _____

FEP BlueDental may release this PHI to:

(*Please Print Legibly)*

Name: _____

Street Address: _____

City, State, Zip _____

Name: _____

Street Address: _____

City, State, Zip_____

I understand that the person(s) I have named to receive PHI may not be subject to privacy laws. They may be able to release the PHI and privacy laws may no longer protect it.

Right to Revoke
I understand that I may cancel this authorization at any time, but it will not affect any release of PHI completed before I cancel it.

Expiration Date: Check one of the two possible choices, below, to signify how long this authorization is valid:

- ☐ For six (6) years after the date it is signed which is the maximum time allowed.
- ☐ Until (specify date if less than six (6) years here) _____

_____ Date: _____
Signature of Member
(Who is granting release of his or her own information)

OR

_____ Date: _____
Signature of Parent
(Only if authorizing release of information pertaining to a minor)

OR

_____ Date: _____
Signature of Personal Representative:
(Include the document which appoints the Personal Representative)

Personal Representative's Name: _____ _____ _____
(First name) (Last name) (Middle initial)

Relationship to Member: _____

Note: You have a right to keep a copy of this form after you sign it.