AUTHORIZED DELEGATE FORM

Instructions: This form is used for you to give Blue Cross and Blue Shield of Louisiana (BCBSLA)** permission to share your protected health information with another person or company (for example, with your spouse or insurance agent). Please fill out Section C with your information and Section D, with the information on the person or company who is to get the information. You must also sign the form in Section F.

**BCBSLA refers to Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana and its subsidiary HMO Louisiana, Inc. (collectively referred to herein as "BCBSLA")

Section A. Purpose

This form is submitted at the request of the person listed in Section C to allow BCBSLA to share that person's protected health information with those listed in Section D.

Section B: Protected Health Information to be disclosed

I give BCBSLA permission to disclose any of my personal information protected by federal or state law to the person(s) or company listed in Section D. I understand that this personal information may contain detailed medical information, except for psychotherapy notes, HIV information, or genetic information. (An additional authorization form is required to release those types of information).

Section C: Member Information (required)

(List the specific person whose information is to be shared, even if that person is not the policy holder.)

*Name: _____

*Address: _____

*City: _____ State: _____ Zip: _____

*Member ID Number: _____ **OR** Social Security Number: _____

Section D: Person(s) or Organization(s) to Receive Information (required)

Name the person or company to whom BCBSLA may give your protected information. We must confirm the identity of the person(s) when they call, so please provide the date of birth or driver's license number of the person or the tax ID number of the company you list below.

Person / Organization #1	Person / Organization #2
*Name_____	*Name_____
*Address_____	*Address_____
*City_____State____Zip_____	*City_____State____Zip_____
*Date of Birth / Tax ID:_____	*Date of Birth / Tax ID:_____
*Driver's License #: _____	*Driver's License #: _____

*This information is required to process the form.

(Over)

Section E: Important Information

No Conditions. BCBSLA will continue providing you with services if you do not complete this form. We will just not be able to share your information with the people you list unless this form is completed.
Further disclosure. If person(s) or company listed in Section D is not required to follow the federal health information privacy laws, they may further share your information and it may no longer be protected by the federal health information privacy laws.
Expiration. This authorization will automatically expire upon BCBSLA's knowledge that you have ended your health insurance coverage.
Right to Revoke. You may withdraw your permission to allow BCBSLA to share your information with those listed on this form by writing to the Privacy Office. Withdrawing your permission will not affect any action taken before we received your letter.

Section F: Member Signature (required)

I, _____, have read and thought about the contents of this form. I agree that the information I put on this form is correct. I understand that by signing this form I am giving permission to BCBSLA to share my protected health information with those listed in Section D.

Signature:_____ Date:_____

If this form is signed by someone <u>other</u> than the member, please complete Section G.

Section G: Legal Representative

If this authorization is signed by a legal representative * or someone other than the member on behalf of the person listed in Section C, complete the following:

Personal Representative's Name: _____

Relationship to the Individual: _____

NOTE: You MUST attach legal documentation of guardianship or Power of Attorney. This documentation is required to process the authorization form.

* Legal representative is a legal designation and generally refers to the parent of a minor, legal guardian, or holder of Power of Attorney.

Privacy Office
5525 Reitz Avenue, Baton Rouge, LA 70809-3802
Phone: (225) 298-1751

Send Completed Forms to:

Customer Service
Blue Cross and Blue Shield of Louisiana
P.O. Box 98029
Baton Rouge, LA 70898-9029
Fax: (225) 297-2727 or (225) 295-2494