

## AUTHORIZATION FORM FOR INFORMATION RELEASE

You may authorize your insurer in writing to share your health information with a third party such as an employer, lawyer, individual broker or unrelated party by completing and submitting this authorization.

**Please print neatly to ensure correct and prompt processing. We reserve the right to return any illegible or incomplete form.**

**1) I, the Undersigned, Authorize:**

Health Plan/Insurer Name: CAREFIRST, PHYSICIAN OFFICES, PHARMACY

**2) To Release Information from the Records of:**

(Complete a separate form for each member whose information is releasable.)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Membership Number: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**3) Information Authorized for Release:** (check all that apply)

- |   |  |
|---|--|
| <input checked="" type="checkbox"/> Claims/EOB Information                            | <input checked="" type="checkbox"/> Enrollment & Benefit Information |
| <input type="checkbox"/> Information pertaining to an Appeal                          | <input type="checkbox"/> Mental Health Records                       |
| <input type="checkbox"/> Alcohol & Substance Records                                  | <input type="checkbox"/> Premium Payment Information                 |
| <input checked="" type="checkbox"/> Other: <u>INFORMATION NEEDED TO RESOLVE ISSUE</u> |  |

(Please specify date of service and or provider name.)

**4) Information may be Released to:** BAMBI KAPUSTIK, THE CAPITAL GROUP

A. Name of Individual or Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

B. Name of Individual or Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

C. Name of Individual or Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

## 5) The Information Will be Used or Disclosed for the Following Purposes:

(Describe the reason for each use and disclosure of the protected health information or indicate "at the request of the individual".)

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### Please read each of the following statements carefully before signing this document.

1. I understand that this authorization will expire one year from the date signed unless a shorter time frame is requested or specific event has occurred.

*Date to expire (can not exceed one year from date signed):* \_\_\_\_\_

*After a Specific Event has Occurred* \_\_\_\_\_

*(e.g. after Heart Surgery or at the End of Pregnancy)*

2. I understand that this authorization is voluntary and being made at my request.
3. I understand that the released information may no longer be protected by federal privacy laws and may be redisclosed by the individual or organization that receives the information
4. I understand that I may refuse to sign this authorization. My health plan will not condition payment, enrollment, or eligibility of benefits on my signing this authorization.
5. I understand that I may revoke this authorization at any time by sending a written notification to the Privacy Office at the address listed below, and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective: (i) for information that my health plan has already used or disclosed, relying on this authorization or (ii) if the authorization was obtained as a condition for coverage in my health plan, and, by law, the health plan has a right to contest the coverage.
6. By signing this form I revoke any previous *Authorization Form for Information Release* signed by me at an earlier date.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If the person signing this form is not the member, the parent, or guardian of a dependent under the age of 18, you must attach a full copy of the official document indicating your legal authority to sign on behalf of the member (i.e. Power of Attorney, Court Assigned Guardian, Personal Representative, etc.).

If you need help completing this form please call 410-308-8300 or toll-free 1-800-853-9236.

Please mail or fax this authorization to:

CareFirst Privacy Office  
10455 Mill Run Circle, YRK - 06  
Owings Mills, MD 21117  
Fax: 410-505-6692

**Please keep a copy of the authorization.  
We will provide you with a signed a copy of this authorization upon request.**

Any mental health or substance abuse information, which has been disclosed from medical or other health care records, may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42CFR Part 2) prohibits the recipient of the information from making any further disclosure of this information unless such disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

