AUTHORIZATION TO RELEASE INFORMATION FORM

Authorization to Disclose Health Information (ADHI) (Medical Coverage)

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. If you have questions, please call the number on the back of your member ID card.

Return completed forms by:

- Portal: Complete and save this form to your desktop to submit through the Member Portal.
  To upload, attach it as part of a request through the Message Center's Contact Us feature.
  When filling out the form please select "General - Other" as your topic.
- Fax: (701) 282-1888
- Mail: BCBSND
  4510 13th Ave S
  Fargo, ND 58121

Section A: Purpose of Form

This form is used to request and authorize Blue Cross Blue Shield of North Dakota to use and disclose my health information with another person or entity.

Section B: Member Information

Please type or print clearly. This individual should sign Section F.

Member ID			Daytime Phone Number	
Last Name	First Name	MI	Suffix	Birth Date (*mm/dd/yyyy*)
Address				
Apartment/Unit/Lot/Suite				
City		State		Zip Code

PLEASE COMPLETE ALL PAGES OF THIS FORM.
If you have questions, please call the number on the back of your member ID card.

Section C: Authorized Use and/or Disclosure

By signing this form, I am allowing Blue Cross Blue Shield of North Dakota to use and disclose my health information as outlined in Section D with the following individual(s) and/or organization(s) listed below.

I understand that if the individual(s) and/or organization(s) is not subject to federal or applicable state privacy laws, my health information may no longer be protected by those privacy laws, and the individual(s) and/or organization(s) may further use and disclose my health information without my authorization. I acknowledge that my authorization is voluntary.

Individual or Entity Name	Phone Number

Address

Apartment/Unit/Lot/Suite

City	State	Zip Code

Section D: Type of Information

I allow the following information to be used or disclosed by BCBSND on my behalf **(CHECK ONLY ONE BOX)**:

☐ **Psychotherapy Notes**: Federal law requires a separate authorization to use or release psychotherapy notes. If you check this box, you may not check another box below.

OR

☐ **All My Information**: Includes health diagnosis, claims, doctors, premium billing and payment information, including maternity, sexually transmitted disease, AIDS, HIV, alcohol, drug or other substance abuse, behavioral and mental health and other sensitive medical information that applicable law may protect.

OR

☐ **Only Limited Information** (*Check all that apply*):

- ☐ Appeal information
- ☐ Benefits and coverage
- ☐ Premium billing and payment
- ☐ Claims and payment
- ☐ Other: _____
- ☐ Eligibility and enrollment
- ☐ Pre-certification and pre-authorization
- ☐ Referral
- ☐ Pharmacy

Note: Certain Federal and State laws require that you give specific permission to use or release the information below, even if you checked a box above. Indicate your permission for the disclosure of the following information by checking all that apply:

- ☐ Alcohol/substance abuse*
- ☐ Other: _____

* I understand that my alcohol/substance abuse records are protected under Federal and State confidentiality laws and regulation and cannot be used or disclosed without my written consent unless otherwise provided for in the laws and regulations.

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Section E: Expiration and Revocation

This authorization will be valid for this one-time release of information unless otherwise specified below. Any date specified cannot exceed 12 months from the date of the covered member's signature below.

☐ Valid for one year from the signature date in Section F.

☐ Earlier than one year and upon the date or event described below:

_____

I may revoke this authorization at any time by giving written notice of revocation to BCBSND Member Services at the address listed on the back of my member ID card. I understand that my revocation of this authorization will not affect any action that you have taken, or any information that you have already released, based upon this authorization before you actually receive my request to revoke it.

Section F: Signature/Authorization

I understand this authorization is voluntary. I understand my treatment, payment, and enrollment in a health plan or eligibility for benefits is not conditioned on receiving this authorization.

I have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization for the use and/or disclosure of my protected health information, as described in this form.

Printed First Name	Printed Last Name
Signature	Today's Date (mm/dd/yyyy)

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In accordance with federal regulations, Blue Cross Blue Shield of North Dakota is required to provide you the following disclosure:

Blue Cross Blue Shield of North Dakota complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, gender identity, sexual orientation or sex. Blue Cross Blue Shield of North Dakota does not exclude people or treat them differently because of race, color, national origin, age, disability, gender identity, sexual orientation or sex.

Blue Cross Blue Shield of North Dakota:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call Member Services at 1-844-363-8457 (toll-free) or through the North Dakota Relay at 1-800-366-6888 or 711.

If you believe that Blue Cross Blue Shield of North Dakota has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, gender identity, sexual orientation or sex, you can file a grievance with:

Civil Rights Coordinator
4510 13th Ave S
Fargo, ND 58121
701-297-1638 or North Dakota Relay at 800-366-6888 or 711
701-282-1804 (fax)
CivilRightsCoordinator@bcbsnd.com (email) (Communication by unencrypted email presents a risk.)

You can file a grievance in person or by mail, fax, or email within 180 days of the date of the alleged discrimination. Grievance forms are available at http://www.bcbsnd.com/report or by calling 1-844-363-8457. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
800-368-1019 or 800-537-7697 (TDD)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*

Español (Spanish)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-363-8457 (TTY: 1-800-366-6888 o 711).

Deutsch (German)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-363-8457 (TTY: 1-800-366-6888 oder 711).

中文 (Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-363-8457（TTY：1-800-366-6888 或 711）。

Oroomiffa (Oromo)

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-844-363-8457 (TTY: 1-800-366-6888 ykn 711).

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.
Gọi số 1-844-363-8457 (TTY: 1-800-366-6888 hoặc 711).

Ikirundi (Bantu – Kirundi)

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu.
Woterefona 1-844-363-8457 (TTY: 1-800-366-6888 canke 711).

العربية (Arabic)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-363-8457 (رقم هاتف الصم والبكم: 1-800-366-6888 أو711).

Kiswahili (Swahili)

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo.
Piga simu 1-844-363-8457 (TTY: 1-800-366-6888 au 711).

Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.
Звоните 1-844-363-8457 (телетайп: 1-800-366-6888 или 711).

日本語 (Japanese)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-363-8457
（TTY: 1-800-366-6888 または 711）まで、お電話にてご連絡ください。

नेपाली (Nepali)

ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-844-363-8457 (टिटिवाइ: 1-800-366-6888 वा 711) ।

Français (French)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.
Appelez le 1-844-363-8457 (ATS : 1-800-366-6888 ou 711).

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-363-8457
(TTY: 1-800-366-6888 또는 711)번으로 전화해 주십시오.

Tagalog (Tagalog – Filipino)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-363-8457 (TTY: 1-800-366-6888 o 711).

Norsk (Norwegian)

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-844-363-8457 (TTY: 1-800-366-6888 eller 711).

Diné Bizaad (Navajo)

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-844-363-8457 (TTY: 1-800-366-6888 éí doodagó 711.)