Authorization for the Release of Protected Health Information (PHI) relating to Substance Use Disorder

BlueCross BlueShield Kansas

There are times when you may want your substance use disorder PHI released to other individuals, treatment Programs, or health care entities. Because your records are confidential, we will need your signed consent to release your PHI. Release of PHI includes both written and verbal information as outlined in the Confidentiality of Substance Use Disorder Patient Records regulation, 42 CFR Part 2 and the HIPAA Privacy Rule 45 CFR Parts 160 & 164.

Parents/Guardians: We want to be able to speak with you on behalf of your dependent child (over the age of 18 or between the ages of 14-18 for certain diagnosis) about their substance use disorder PHI. In order to do this, we are required to have their written consent.

If you want to share your substance use disorder PHI with someone else, please complete all sections carefully and return to Blue Cross and Blue Shield of Kansas (BCBSKS). This form is available online at **bcbsks.com.**

Section 1 – Person Authorizing Release

Clear form

First Name _____ Mailing Address _____

Last Name _____ City _____

Member Identification Number _____ State _____ ZIP Code _____ +4 _____

Date of Birth ____ / ____ / ____

☐ I am the parent/guardian and authorize the release of substance use disorder PHI for my dependent listed below:

First Name _____ Last Name _____ Date of Birth ____ / ____ / ____

Section 2 – Release of Protected Health Information (PHI)

I authorize BCBSKS to release PHI pertaining to substance use disorder under the following limitations:

Information with: _____
(specific names or general designations of the 42CFR part 2 programs, entities or individuals permitted to share PHI)

To be shared with: _____
(name of person, treating provider, or entity the PHI can be shared with)

During the time period: From: ____ / ____ / ____ to ____ / ____ / ____
MM DD YYYY MM DD YYYY

Description of the substance use disorder information that my be disclosed (be specific):

Note: Members have the right to obtain a list of entities to whom their information has been disclosed. This must be submitted through the BCBSKS Customer Service Center toll free at 1-800-432-3990.

Please continue on next page. Your signature is required. ▶

Section 3 – Authorization

I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations unless the information being disclosed is protected by federal alcohol and substance abuse regulation (FASAR). I understand that BCBSKS does not condition payment, enrollment, or eligibility for benefits on whether I sign this authorization. This authorization is valid until I no longer have coverage with BCBSKS, dependents reach the age of 18, or until such time as written revocation has been received by BCBSKS.

In addition, I understand that I may revoke this authorization at any time by notifying BCBSKS in writing and that revocation of this authorization will not affect any action taken in reliance of this authorization before the written revocation was received. **If signing authorization as Power of Attorney, Power of Attorney for Health Care or Guardian/Conservator, a copy of the legal document must accompany this form.**

Your signature required

_____ _____ / _____ / _____
Applicant Date Signed

_____
Print Name

When completed, please mail to:

Blue Cross and Blue Shield of Kansas
1133 SW Topeka Blvd., Topeka, KS 66629-0001

Note: Please keep a copy of this form for your files.

Internal Use Only

Return to _____

Mail stop _____