The Following Replaces The First Three Paragraphs Of Section
"AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION"
On Your Application

CONDITIONED AUTHORIZATION TO USE OR OBTAIN MEDICAL INFORMATION FOR ENROLLMENT OR TO PAY CLAIMS

Name ______________________ ID # ______________________ Phone # ______________________

Address (Street, City, State, Zip) ____

Protected Health Information (PHI) to be Used and/or Disclosed: Any and all information or records relating to the medical history, medical examinations, services rendered, or treatment given, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, A.I.D.S. (Acquired Immune Deficiency Syndrome), or A.R.C. (AIDS-related complex).

Entities or Persons Authorized to Use or Disclose: U.S. Department of Health and Human Services (including the Centers for Medicare & Medicaid Services and any contractors or agents, including Medicare intermediaries), any physician or other health care professional, hospital or other health care facility, counselor, therapist or any other medical or medically related facility or professional.

Entities or Persons Authorized to Receive: Blue Cross of California or affiliate ("Blue Cross") its agents, employees, designees, or representatives, including my Blue Cross agent or broker.

Purpose of this Authorization:

By signing this form, you will authorize us to use and/or disclose your Protected Health Information (PHI) to determine if you will be enrolled in our health plan or are eligible for benefits, or for underwriting or risk rating your enrollment or eligibility. This authorization is a condition of your enrollment in our health plan or your eligibility for benefits.

Obtain your Protected Health Information (PHI) from other covered entities so that we may determine payment of a claim for specified benefits involving you.

Cont'd on Page Two
(Complete Entire Authorization)

Effect of Declining:

If you decide not to sign this authorization, we may decline to enroll you in our health plan or to give you the benefits. This PHI used or disclosed may be subject to re-disclosure by the recipient, in which case it would no longer be protected under the HIPAA Privacy Rule. This authorization is a condition of our paying the claim.

Expiration: This authorization will expire upon termination of any Blue Cross coverage that may be in effect.

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to:

Blue Cross of California
PO. Box 9063, Oxnard, CA 93031-9063
Telephone 800-333-3883, Fax 805-375-0361

I understand that revocation of this authorization will not effect any action you took in reliance on this authorization before you received my written notice of revocation.

I have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this authorization, I am confirming my authorization of the use and/or disclosure of my Protected Health Information, as described in this authorization.

____

Print Name **Signature** **Date**

If this authorization is signed by a personal representative, on behalf of the individual, complete the following:

____

Personal Representative: Print Name Relationship to Individual

____

Signature Date

A photocopy of this authorization is as valid as the original, and I and my Blue Cross agent or broker are entitled to receive a copy of this form. YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

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