Health Options
Highmark Blue Cross Blue Shield Delaware

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Please complete all sections below that apply:

Member's Full Name:			
Date of Birth:		**Health Options ID No.:**	
Member's Address:			
Description of Information to be Used or Disclosed:			
Who Is Authorized to Use or Disclose the Information?			
Highmark BCBSD Health Options Inc.			
Who Is Authorized to Receive the Information?			
Reason(s) the Information Will Be Used or Disclosed: (If the member initiates the authorization, the statement "at the request of the individual" is sufficient.)			
Expiration Date or Event: (Provide Date or Check Disenrollment Option)			
Expiration Date: _____ or Upon Disenrollment from Plan: _____			
If you are not the Member, what is your relationship to the Member:			
What is your address?			
What is your telephone number?			

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM.

NOTICE TO MEMBER

The Authorization to Use and Disclose Protected Health Information is voluntary. By signing this Authorization, I am confirming that the person or organization listed on the previous page may disclose my Protected Health Information as stated. I understand that, if the person or organization that I have authorized to receive the information is not subject to federal health information privacy laws, the information may be re-disclosed and will no longer be protected by federal privacy laws. I understand that giving this authorization is not a condition of obtaining health services, eligibility for benefits enrollment or payment of claims.

I understand that I may revoke this authorization at any time by writing Health Options. I understand that Health Options may still disclose information if it has already taken action based on a previously completed authorization.

Signature: _____ **Date:** _____

If this authorization is signed by someone who is not the member listed at the top of this form, attach any documents (e.g., general power of attorney) that verify the signer's authority to act for the member. The member will be provided with one copy of this form.

Translation services are available at no cost by calling 1-844-325-6251.