Regence

Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this form, you give any carrier identified on the cover sheet of this application the right to gather medical information about you and your dependents for whom you have legal authority to sign (e.g., a minor child). A carrier typically gathers both paper and electronic records. This information, for example, helps a carrier evaluate your application for enrollment and process your medical claims after enrollment.

A. Underwriting Authorization

I authorize any health plan and any health care provider (including any pharmacy) to disclose medical information about me to a carrier for purposes of determining my eligibility for health insurance coverage as requested in this application. The medical information I authorize to be disclosed includes any medical information related to my insurability except for any private genetic information about me or a blood relative of mine. (The law prohibits carriers from using private genetic information for underwriting purposes.)

B. General Acknowledgment

I acknowledge and understand that after enrollment the carrier will have the right to request or disclose health information about me or my dependents (persons who are eligible for benefits coverage and are listed on the Application form) from time to time for the purpose of facilitating health-care treatment, payment or for the purpose of business operations necessary to administer health care benefits, or as required by law. Health information requested or disclosed may be related to treatment or services performed by:

- a physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- a clinic, hospital, long-term care or other medical facility;
- any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or;
- an insurance carrier or health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). This acknowledgment does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

C. Information for Applicant and Dependents

I understand the following information:

1. I may refuse to sign this Authorization, or I may revoke it if I have not been enrolled in a plan by sending my written request to the carrier; however, if I do so the carrier may refuse to enroll me and my revocation will not apply to any disclosure made by the Plan prior to my revocation;
2. A health care provider may not condition my treatment on signing this Authorization;
3. Another health plan may not condition payment, enrollment, or eligibility for benefits on my signing this Authorization;
4. I understand that the information the carrier receives because of this Authorization may be redisclosed and no longer protected by federal or state regulation. Items 5 and 6 of this section limit the potential for redisclosure of my information;
5. If enrollment does not occur the carrier may not use or disclose the information it receives because of this Authorization for any purpose other than underwriting, except as may be required by law. (If the carrier denies insurance coverage because of an individual's health condition, Utah law requires the carrier to tell the applicant specifically what this health condition is);
6. If enrollment does occur the carrier will only use information disclosed under this Authorization for purposes described in its notice of privacy practices;
7. This authorization will expire 90 days after it is signed if enrollment does not occur in the plan and 180 days after my coverage terminates if enrollment does occur;
8. If your application contains any material misstatements or omissions, Regence BCBSU may deny coverage, retro-actively terminate coverage, cancel coverage and/or take any other legal action available to us by law.

D. Identifying Signatures for Applicant and Dependents 18 years of age or older

For additional dependents over the age of 18, please attach a separate sheet of paper with Dependent Names, Date of Birth's, Signatures and Date Signed.

Applicant	Date of Birth (mm/dd/yyyy)	Signature*	Date Signed (mm/dd/yyyy)
Spouse	Date of Birth (mm/dd/yyyy)	Spouse's signature or representative with legal authority**	Date Signed (mm/dd/yyyy)
Dependent	Date of Birth (mm/dd/yyyy)	Dependent signature or representative with legal authority**	Date Signed (mm/dd/yyyy)
Dependent	Date of Birth (mm/dd/yyyy)	Dependent signature or representative with legal authority**	Date Signed (mm/dd/yyyy)
Dependent	Date of Birth (mm/dd/yyyy)	Dependent signature or representative with legal authority**	Date Signed (mm/dd/yyyy)
Dependent	Date of Birth (mm/dd/yyyy)	Dependent signature or representative with legal authority**	Date Signed (mm/dd/yyyy)

***If the main applicant's signature is completed by a legally authorized personal representative, please complete the following:**

Personal Representative's Name (please print)_____

Relationship to Individual_____(if applicable, attach legal documentation)

**Generally, spouses and dependents 18 years of age or older must sign for themselves.