Authorization Form for Information Release

You may authorize your insurer in writing to share your health information with a third party such as a family member, employer, lawyer, broker or unrelated party by completing and submitting this authorization.

Please type or print neatly. We will not process incomplete or illegible forms.

Please mail or fax this authorization to: CareFirst BlueCross BlueShield, Privacy Office, PO Box 14858, Lexington, KY 40512
Email: **privacy.office@carefirst.com** Fax: 410-505-6692

Please keep a copy of this authorization for your records.

AUTHORIZATION OF INFORMATION RELEASE IS GIVEN TO

Name of Health Insurance Plan
CareFirst BlueCross BlueShield

TO RELEASE RECORDS OF

Last Name, First Name, MI		Member ID
Street Address		
City	State	ZIP
Home Telephone	Work Telephone	Date of Birth (mm/dd/yyyy) / /

INFORMATION TO BE RELEASED

Check all that apply:

- ☑ Enrollment & benefit information
- ☑ Authority to initiate an appeal and/or information pertaining to an existing appeal
- ☑ Claims/explanation of benefits information

To include:

- ○ Substance use disorder information
- ○ Mental health information

○ Other _____

INFORMATION MAY BE RELEASED TO

Name of Individual	Name of Organization (if applicable)	
	Silberstein Insurance Group	
Street Address		
2850 Quarry Lake Dr., Ste 303		
City	State	ZIP
Baltimore	MD	21209
Name of Individual	Name of Organization (if applicable)	
Street Address		
City	State	ZIP
Name of Individual	Name of Organization (if applicable)	
Street Address		
City	State	ZIP

REASON FOR THE RELEASE OF INFORMATION

Describe the reason for each use and disclosure of the protected health information or indicate "at the request of the individual".

At the request of the individual

PLEASE READ EACH OF THE FOLLOWING STATEMENTS CAREFULLY BEFORE SIGNING THIS DOCUMENT

1. I understand that this authorization will expire one year from the date signed unless a shorter time frame is requested or a specific event has occurred.

   Date to expire (less than one year): _____

   After a specific event has occurred: _____

   (e.g., after heart surgery or at the end of pregnancy)

2. I understand that this authorization is voluntary and is initiated at my request.
3. I understand that the released information may no longer be protected by federal privacy laws and may be re-disclosed by the individual or organization that receives the information.
4. I understand that I may refuse to sign this authorization. My health plan will not condition payment, enrollment, or eligibility of benefits on my signing this authorization.
5. I understand that I may revoke this authorization at any time by sending a written notification to Privacy Office at the address listed on page 1 and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective: (i) for information that my health plan has already used or disclosed, relying on this authorization; or (ii) if the authorization was obtained as a condition for coverage in my health plan and, by law, the health plan has a right to contest the coverage.
6. By signing this form, I revoke any *Authorization Form for Information Release* that I previously signed.

Signature	Date

Must be the original signature of any person 18 years of age or older whose records have been requested. If this request is made by a personal representative on behalf of the individual, please attach a complete copy of the personal representative form or legal document indicating your legal authority to sign this form.

Any mental health or substance use disorder information, which has been disclosed from medical or other health care records, may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CFR Part 2) and/or Washington, D.C. and Maryland mental health laws prohibit the recipient of the information from making any further disclosure of this information unless such disclosure is expressly permitted by the written consent of the person to who it pertains, or as otherwise permitted by 42 CFR Part 2 and/or Washington, D.C. and Maryland mental health laws. 42 CFR Part 2 prohibits unauthorized disclosure of these records.