



**BlueCross BlueShield  
of Illinois**

**Standard Authorization to Use or Disclose Protected Health Information (PHI)**

Unless instructed otherwise, return this form to: Blue Cross and Blue Shield of Illinois, P.O. Box 1364, Chicago, IL 60690-1364

**Section A: The individual for whom this authorization is being requested. Please complete the following:**

Name _____	Group # _____	Identification\Subscriber # _____
Social Security Number _____	Date of Birth _____	
Address _____	City _____	State _____ ZIP _____
Area Code & Telephone Number _____	E-mail Address (if available) _____	Country _____

**Section B: Who will provide this information?**

Name	Blue Cross/Blue Shield of IL
Dept.	Membership and Claims
Address	300 E. Randolph Chicago, IL 60601

**Section C: Who will receive this information?**

Name	Christina Bowers	Jean Tritle
Dept.	Julie Hanes American Nat'l Insurance	City of Sycamore
Address	1985 DeKalb Ave Sycamore, IL 60178	308 W State St Sycamore, IL 60178

**Section D: Describe the specific Protected Health Information to use or disclose, including date(s):**

Any eligibility and claims information for the period of: \_\_\_\_\_

This authorization will expire on: \_\_\_\_\_ (insert date or event).

Describe the reason for the release or request of information:

At the request of the individual.

Other: \_\_\_\_\_

**Section E: I understand that:**

- This authorization will expire on the date or event listed in Section D above.
- This authorization is voluntary.
- Payment, enrollment or eligibility for benefits for my health care will not be affected if I do not sign this form.
- I may revoke this authorization at any time by notifying in writing the company/individual listed in Section B from providing the PHI identified in this authorization, but if I do revoke this authorization, it won't have any affect on any actions Blue Cross and Blue Shield of Illinois took before they received the revocation.
- Information disclosed as a result of this authorization may no longer be protected by federal privacy laws and may be disclosed by the company or individual receiving the information.
- I should retain as my copy one of the duplicate authorization forms I received.

**Section F: Signature.**

I hereby authorize the use or disclosure of the Protected Health Information as described in Section D for the Individual listed in Section A.

\_\_\_\_\_  
Signature of Individual or Individual's Personal Representative

\_\_\_\_\_  
Date: month/day/year

**Section G: If Section F is signed by a Personal Representative, please complete the information below:**

Personal Representative's Name _____	Relationship to Individual _____
Personal Representative's Address _____	City _____ State _____ ZIP _____
Personal Representative's Area Code & Telephone Number _____	Personal Representative's E-mail address (if available) _____ Country _____