



# Authorization for Use of Protected Health Information



By signing below:

I authorize Blue Cross of California, or an agent, subsidiary or affiliate that has a business associate contract with Blue Cross of California, to obtain any medical records (but not including psychotherapy notes) from any physicians, hospitals and/or other health care providers concerning my care and the care of any family member listed on my Application or Change of Coverage Form.

I also authorize any physicians, hospitals and/or other health care providers to furnish any medical records (but not including psychotherapy notes) concerning my care and the care of any family member listed on my Application or Change of Coverage Form to Blue Cross of California, or an agent, subsidiary or affiliate that has a business associate contract with Blue Cross of California. This information is needed to determine eligibility for the coverage requested for myself and/or any family members listed on my Application or Change of Coverage Form.

I understand that the entities indicated above can request medical records for up to the past 10 years and this information will be used to determine whether I and my listed family members are eligible for enrollment in the coverage requested.

I understand that this form must be signed and returned with my completed Application if I am initially applying for enrollment in a medically underwritten health plan offered by Blue Cross of California or its affiliate, BC Life & Health Insurance Company, or signed and returned with my completed Change of Coverage Form if I wish to add a family member or upgrade my coverage. This Authorization will expire when determination is completed regarding my/our eligibility for coverage.

I understand that I may revoke this Authorization at any time while Blue Cross of California is determining eligibility for the coverage requested. To do so, I must submit a completed Authorization Revocation Form to Blue Cross of California. An Authorization Revocation Form is available by writing to: Blue Cross of California, P.O. Box 9041, Oxnard, CA 93031. If I revoke this Authorization after I initially apply for coverage, I understand that I/we will not be considered by Blue Cross of California for enrollment in one of its medically underwritten health plans. If I revoke this Authorization after I ask to upgrade my coverage or add a family member, I understand that the change will not be made.

\_\_\_\_\_  
Printed name of Applicant/Member

\_\_\_\_\_  
Signature of Applicant/Member or his/her Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of Spouse or Dependent Child age 18 or over listed on Application

\_\_\_\_\_  
Signature of Spouse/Dependent Child\* or his/her Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of Dependent Child age 18 or over listed on Application

\_\_\_\_\_  
Signature of Dependent Child\* or his/her Personal Representative

\_\_\_\_\_  
Date

*\*If listed on your Application or Change Form, your spouse and each dependent child age 18 or over must sign above.*

If this Authorization is signed by a personal representative on behalf of the Applicant/Member, Spouse and/or Dependent Child(ren), the representative must complete the following:

\_\_\_\_\_  
Printed name of Personal Representative

\_\_\_\_\_  
Relationship to Applicant/Member, Spouse and/or Dependent Child(ren)

\_\_\_\_\_  
Date

*A photocopy of this form will be as valid as the original.  
You have the right to receive a copy of this Authorization upon request.*