

*A special notice to our members from the
Comprehensive Health Association of North Dakota (CHAND)*

ABOUT YOUR PRIVACY

The privacy of your health information has always been of crucial importance. It is our policy and our obligation under federal and state laws to protect the privacy of our members' information. We need your understanding and cooperation to help ensure compliance with these laws.

AUTHORIZATIONS TO RELEASE INFORMATION: When you contact us about a claim or would like other health information involving your spouse or dependent, before we can disclose information to you, we need to be sure that we have permission to do so or that you have the authority under state or federal law to receive this information.

For members age 18 or over, it is our policy to have a written authorization on file signed by the person whose information you are requesting, or have some other type of documentation showing you have the authority under state or federal law to receive information (e.g. a power of attorney, an appointment of guardianship, a court decree, etc.)

We also recommend having written authorization for members between ages 12 and 17. Although parents and other legal representatives generally have the authority to obtain information about their minor children, there are laws that give minors special protections regarding certain kinds of health information. In these cases, the law requires that we have the written permission of the minor child before we may disclose this information, including to their parents. By submitting an authorization to us in advance, you speed up the process of obtaining your minor child's health information, including information with special protections, when you contact us later. Without this form, CHAND must do a manual review of the minor's health information to determine what information can be provided to you. Because of this manual review, there may be a delay in our response to you.

Authorization forms are available by contacting our CHAND Service Center (1-800-737-0016) or by visiting a Blue Cross Blue Shield of North Dakota office near you. You may also download this form from www.CHAND.org.



*4510 13th Avenue South
Fargo, ND 58121-0001*

1-800-737-0016

Lead Carrier services provided by Blue Cross Blue Shield of North Dakota

Authorized Representative Form

Section A: Member information (Please type or print clearly)

Member name: _____ Birth date: _____

Address: _____

City: _____ State: _____ Zip: _____

Day telephone: _____ Benefit Plan number(s): _____

Section B: Purpose of form

This form is used to document the designation of Authorized Representatives for a Member, including a minor who has the right under applicable law to control whether a parent or guardian may have access to the minor's health information. This form authorizes the release of the Member's health information to the Authorized Representative(s) designated on this form.

Section C: Type of information

I understand that by completing this form I am allowing you to use my health information with and disclose it to my Authorized Representative(s) designated on this form, including any health information in my records relating to (please strike through any of the following health information you do not want to be available to the Authorized Representative(s) you designate on this form):

- sexually transmitted disease;
- acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV);
- alcohol, drug or other substance abuse;
- behavioral or mental health services;
- other sensitive medical information that applicable law may protect from use or disclosure without the Member's permission.

Completion of this form is entirely voluntary. Your refusal to authorize disclosure of your health information to Authorized Representatives will have no effect on our enrollment of you in our health plans, your eligibility for benefits under our health plans or the amount we pay for the health services you receive. Please note that whether or not you elect to complete this form will have no effect on the ability of a personal representative, such as a parent, guardian, or person acting in the capacity of a parent or guardian, to have access to certain of your health information when applicable law allows such access without your written permission.

Section D: Authorized use and/or disclosure

I understand that, if my Authorized Representative is not subject to federal or applicable state privacy laws, my health information may no longer be protected by those privacy laws and my Authorized Representative may further disclose my health information without my authorization. I acknowledge that my authorization is voluntary.

Authorized representative #1:

Name: _____ Day time phone number _____

Address: _____

Relationship to you: _____

Please complete both sides of this form

Authorized representative #2:

Name: _____ Day time phone number _____

Address: _____

Relationship to you: _____

If you want to restrict the information that the Authorized Representative may receive, indicate those restrictions below. We may not agree to your restrictions. You will be notified if we are unable to agree.

Section E: Expiration and revocation

For North Dakota residents, this authorization will remain in effect for 18 months past your Plan(s) termination date. For residents of all other states, this authorization will terminate 12 months from the date of signature below. If you are under 18 years of age, this authorization will terminate as of your 18th birthday.

By checking this box, I am indicating that I wish this authorization to terminate in the event of my death. If this box is not checked, this authorization will remain valid as indicated above.

I understand that I have the right to revoke or end this authorization at any time. I understand that, if I do not wish the person(s) named in Section D to remain my Authorized Representative(s), I must revoke this authorization **in writing** by giving written notice of my decision to Member Services at the address listed below. I understand that my revocation of this authorization will not affect any action that you have taken, or any information that you have already released, based upon this authorization before you actually receive my request to revoke it. I also understand that my revocation may not be effective in preventing release of certain health information to a personal representative, such as a parent, guardian, or person acting in the capacity of a parent or guardian, who applicable law allows to have access to such health information without my written permission.

Section F: Signature/authorization

Signature

Date

UPON REQUEST, YOU ARE ENTITLED TO A COPY OF THIS FORM AFTER YOU SIGN IT.
Please notify us of any changes to the information provided on this form.



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