

CONFIDENTIAL INFORMATION RELEASE FORM - HIV



An Independent Licensee of the Blue Cross and Blue Shield Association

Use this form to let a person get your HIV-related information. Even if you don't sign it, Blue Cross Blue Shield of Arizona (BCBSAZ) will still pay your claims, sign you up for our plan and let you be eligible for benefits. This form is not required.

I authorize BCBSAZ to give my HIV-related information (tests for HIV, AIDS or related illnesses) to:

Name: _____

Street Address: _____

City, State, Zip Code: _____

Reason for giving out the information: _____

This permission starts the day you sign this form. It will be good for 180 days. The person who gets your records may not keep them private. If that happens, your records may not be protected by federal privacy laws.

You may tell us to stop sharing your records at any time. **If you want us to stop sharing, write to us at: BCBSAZ Privacy Office, Mail Stop C302, P. O. Box 13466, Phoenix, AZ 85002-3466. If you tell us to stop sharing, it will not change what BCBSAZ shared before you told us to stop.**

Member's Name: _____ BCBSAZ ID Number: _____

Member's Signature: _____ Date Signed: _____

Group Name (if this applies): _____ Group Number (if this applies): _____

Representative's Name*: _____ Relationship to Member: _____

Representative's Signature: _____ Date Signed: _____

* Attach a copy of the legal paper(s) that apply.

PLEASE HAVE A NOTARY SIGN THE FORM

State of _____ County of _____

This form was signed before me on: _____

Notary Public: _____

My commission expires: _____

You can get a copy of this form after you sign it. You may refuse to sign this form.

Please send us the filled out form.

Mail it to: **BCBSAZ, Attention: Enrollment, P.O. Box 13466, Phoenix AZ 85002-3466;**

Fax it to: **602-864-4041** or Email it to: **privacy@azblue.com**

Blue Cross Blue Shield of Arizona (BCBSAZ) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BCBSAZ provides appropriate free aids and services, such as qualified interpreters and written information in other formats, to people with disabilities to communicate effectively with us. BCBSAZ also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call 602-864-4884 for Spanish and 1-877-475-4799 for all other languages and other aids and services.

If you believe that BCBSAZ has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: BCBSAZ's Civil Rights Coordinator, Attn: Civil Rights Coordinator, Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466, 602-864-2288, TTY/TDD 602-864-4823, crc@azblue.com. You can file a grievance in person or by mail or email. If you need help filing a grievance BCBSAZ's Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.



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