Blue Shield of California and Blue Shield of California Life and Health Insurance Company

AUTHORIZATION FOR RELEASE OF INFORMATION

Purpose: This form is used to authorize disclosure of protected health information that may be included in the records you are authorizing us to release.

SECTION A: Individual authorizing release of information

Name_____ Subscriber No._____
City_____ State_____ Zip_____

SECTION B: Records authorized for release

By signing this form you are authorizing and directing Blue Shield of California (BSC) and Blue Shield of California Life and Health Insurance Company ("Blue Shield Life") to release the following records that may contain protected health information (check all that apply):

- [X] Explanation of Benefits
- [X] Claims Submitted by Providers
- [ ] Other_____

_____

No Conditions: This authorization is voluntary. We will not condition your enrollment in a health plan, eligibility for benefits or payment of claims on giving this authorization.

Effect of this Authorization: Your protected health information will be disclosed to the persons/companies you have designated. Once disclosed, your information may no longer be protected by federal or state privacy laws.

Release Records To: [specify the name, address and telephone number of the person/company to whom we should release the records, and the purpose for the release]

C/O CD Photocopy Service
17371 Irvine Blvd., First Floor
Tustin, CA 92780
Discovery for Worker's Compensation Claim

SECTION C: Expiration and revocation

Expiration: This authorization will expire one year from the date this authorization form is signed.

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to BSC and Blue Shield Life. I understand that revocation of this authorization will *not* affect any action BSC and Blue Shield Life have taken in reliance on this authorization before receiving my written notice of revocation.

Custodian of Records
Blue Shield of California / Blue Shield of California Life and
Health Insurance Company
Law Department
50 Beale St.
San Francisco, CA 94105

INDIVIDUAL'S SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this form, I am confirming authorization of disclosure of my protected health information, as described in this form.

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following and attach copies of documents demonstrating your right to execute this authorization.

Personal Representative's Name:

_____

Relationship to Individual:

_____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT