



An Independent Licensee  
of the Blue Cross and  
Blue Shield Association

## CONFIDENTIAL INFORMATION RELEASE FORM - HIV (To authorize BCBSAZ to disclose HIV-related information)

Send completed forms to Blue Cross Blue Shield of Arizona, Attention: Enrollment Services, P.O. Box 13466, Phoenix, Arizona 85002. Blue Cross Blue Shield of Arizona (BCBSAZ) will not condition its payment activities in connection with your claims, your enrollment in our health plan or your eligibility for benefits in our health plan on you giving this authorization.

I authorize BCBSAZ to release confidential HIV-related information (HIV-related tests, presence of HIV infection and/or HIV-related or acquired immune deficiency syndrome illnesses) to:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip code \_\_\_\_\_

The individual named above will be entitled to receive this information for the purpose of:

\_\_\_\_\_  
\_\_\_\_\_

This authorization will be effective as of the date signed and will be valid for one hundred eighty (180) days from the effective date. It is possible for the protected health information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer protected by federal health information privacy laws.

I understand that I may revoke this authorization by giving written notice to the BCBSAZ Privacy Office, C302, BCBSAZ, P.O. Box 13466, Phoenix, AZ 85002-3466. I understand that revocation of this authorization will not affect any action BCBSAZ took in reliance on this authorization before it received my written notice of revocation.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Identification Number

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Group Name (if applicable)

\_\_\_\_\_  
Group Number (if applicable)

\_\_\_\_\_  
Personal Representative's Name\*

\_\_\_\_\_  
Relationship to Individual

\_\_\_\_\_  
Personal Representative's Signature

\_\_\_\_\_  
Date

\* Please attach a copy of the relevant legal document(s).

### PLEASE OBTAIN NOTARY SIGNATURE

State of \_\_\_\_\_ County of \_\_\_\_\_

The foregoing instrument was acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_.

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
My commission expires:

**You are entitled to a copy of this authorization after you sign it.  
You may refuse to sign this authorization.**