



**BlueCross BlueShield  
of New Mexico**

Dear Member:

**We need your okay before we can give out your records to others.  
Just fill out and sign this form.**

We've been asked to release your records to a person or company. Before we can do this, we need you to fill out the form that is with this letter. Then send it back to us. This form will tell us who can receive your records.

**The form will be good for one year from the date you sign it unless you ask for it to end sooner.**

Please be sure to fill out the whole form. Keep a copy for your records. Please don't change the form or leave things out. If there are problems, or if we have questions, we'll send you a letter or call you.

Once we get your signed form, we will process it quickly. If you have any questions, please call Customer Service at 1-866-689-1523.

Sincerely,

Customer Advocate

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Blue Cross Community Centennial<sup>SM</sup> • P.O. Box 27838 • Albuquerque, NM 87125-7838 • 1-866-689-1523 • bcbsnm.com

Such services are funded under contract with the State of New Mexico

Blue Cross and Blue Shield of New Mexico is a Division of Health Care Service Corporation, a Mutual Legal Reserve Company,  
an Independent Licensee of the Blue Cross and Blue Shield Association

L\_CC195 Privacy SSB HIPAA Member Authorization 2.0\_08\_22\_22

Please read the following for help completing page one of the form.

**PART A: Member**


- Print your last name, first name, and the first letter of your middle name.
- Write your date of birth like this: mm/dd/yyyy. For example, if you were born on October 5, 1960, you would write 10/05/1960.
- Write your full street address, city, state, and ZIP code.
- Write a daytime phone number (including area code) where you can be reached.
- **Member ID number**
  - This number is on your member ID card.
- **Group number**
  - This number is on your member ID card. If your ID card does not have a group number, leave this part blank.

**PART B: People or companies who will get my records**

- Check the box of the person or company who can see your records. Also, tell us the full name of the person or company to give your records to. Please do not use a general term like “my daughter” or “my son.” You need to be very clear.
- If you check “Other,” please give:
  - The first and last name (if you have it).
  - The company name (if this applies to you). And what they have to do with you.

**PART C: My records**

- Tell us what records you will let us give out: all or just some.
- To give out all of your records, check the first box.
- To give out only some records, check the second box.
- There is also a section about things that you think are very personal or very private to you. If you agree that we can give out these types of records, check the boxes that apply to you.



**BlueCross BlueShield  
of New Mexico**

Member Authorization Form

This form must be filled out by a member. It allows a person or company to see the member's records. Please write in as much about yourself as you can. If you need help, see the letter that's with this form. It will show you how to fill out each part. Also, you can call the number on your member ID card.

PART A: MEMBER			
Member last name	Member first name	Middle initial	Member date of birth
Member street address	City	State	ZIP code
Daytime phone number (with area code)	Member ID number (see member ID card)	Group number (see member ID card)	

PART B: PEOPLE OR COMPANIES WHO WILL GET MY RECORDS	
The people or companies listed and checked below have the right to see my records. (They must be 18 or older). Please check each box that applies. Write in first and last names.	
<input type="checkbox"/> My spouse (first and last name)	<input type="checkbox"/> My parents (If you are over 18, write in first and last names)
<input type="checkbox"/> My adult children (first and last names)	<input type="checkbox"/> Other (First and last name if you have it. This could be a person or the name of company. Also write what this person or company has to do with you.)

PART C: MY RECORDS	
I will let Blue Cross Community Centennial share the records below (check only one box):	
<input type="checkbox"/> <b>All my health records.</b> All my health records. This can be records about your health, a diagnosis (name of illness or health problem), claims, names of doctors and other health care providers. Records also can be about money (like billing and banking). Checking this box won't let others see sensitive (very personal) records unless I agree to it below. <b>OR</b>	
<input type="checkbox"/> <b>Only some records</b> (check all that apply to you)	
<input type="checkbox"/> Appeal	<input type="checkbox"/> Pre-certification and pre-authorization (for treatment approvals). This is when we give you an OK for a treatment.
<input type="checkbox"/> Benefits and coverage	<input type="checkbox"/> Referral (when your main doctor says it's OK to see a special doctor for certain treatment)
<input type="checkbox"/> Bills	<input type="checkbox"/> Treatment
<input type="checkbox"/> Claims and payment	<input type="checkbox"/> Dental
<input type="checkbox"/> Diagnosis (name of illness or health problem)	<input type="checkbox"/> Vision
<input type="checkbox"/> Eligibility	<input type="checkbox"/> Pharmacy
<input type="checkbox"/> Doctor and hospital	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Doctor's records	
<input type="checkbox"/> Money areas	
I also will let BCBSNM share this type of sensitive (very personal) records below. Check all boxes that apply to you.	
<input type="checkbox"/> <b>All sensitive records below</b>	
<b>OR</b>	
<input type="checkbox"/> <b>Just some records about topics checked below:</b>	
<input type="checkbox"/> Abortion	<input type="checkbox"/> Being pregnant
<input type="checkbox"/> Abuse (sexual/physical/mental)	<input type="checkbox"/> Mental health
<input type="checkbox"/> Alcohol and drug abuse*	<input type="checkbox"/> Sexual diseases passed on to others
<input type="checkbox"/> Testing of genes	<input type="checkbox"/> Other: _____
<input type="checkbox"/> HIV or AIDS	

\*I know that my alcohol and drug abuse records are protected under federal and state laws and rules. This form will keep these records private. No records can be given out without my saying so in writing. This is unless it says so in the laws and rules. I also know that I may take back the fact that I agreed to this at any time. Or, as it is shown below, I know that I cannot cancel this signed form after we have given out your health records.

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Please read the following for help completing page two of the form.

**PART D: Why you want your records shared**

- The first box tells us to give out your records as shown on this form.
- The second box tells us a special reason. This could be talking about a life insurance claim. This might be with a lawyer or family member. Write your reason in the space.

**PART E: Review and sign**

- Once you sign the form, it will be good for one of the following amounts of time:
  - Check the first box for one year. That’s the normal time.
  - Check the second box to say the form you sign will be good for less than a year. Then give the date you want it to end.
- **Sign your name and put the date on the form.** Your name and signature *must* match what you wrote in PART A.
- You may be signing this form for someone else. If you have forms that say you have Power of Attorney for health care, or are a legal guardian or conservator, you must do this:
  - Fill in **Named Legal Person or Guardian**.
  - Give us a copy of the legal form that shows you have Power of Attorney. Put it in with this form.

PART D: WHY YOU WANT YOUR RECORDS SHARED			
<input type="checkbox"/> For the reasons shown on this form <b>OR</b> <input type="checkbox"/> Special reason(s): _____			
PART E: REVIEW AND SIGN			
Once I sign and send in the form, it will be good for: <input type="checkbox"/> One year from the day I signed the form <b>OR</b> <input type="checkbox"/> Before one year and on the date, event or reason shown			
I have read each part of this form. I know, agree, and will let Blue Cross Community Centennial use and give out my records as I have stated above. I also know that I signed this form of my own free will. I know that I don't need to sign this form to get treatment or payment, or for signing up for or getting benefits. I have the right to take back what I agreed to in this form at any time. I will tell Blue Cross Community Centennial in writing that I'm doing so. I know that taking this back will not change any action taken before I do so. I also know that any records that a person or group gets (that I've agreed to) may be given out. If this happens, the records may no longer be protected under the HIPAA Privacy Rule.			
Member signature (If member is a minor, parent's signature)			Date
X			
You have the right to keep a copy of this form after you fill it out. Please make a copy for your records. Return this completed form in the envelope we sent you with this form.			
NAMED LEGAL PERSON OR GUARDIAN			
If there is a person who is signing for the member, (someone who takes care of the member), we need these forms filled out: A copy of a health care, general or Durable Power of Attorney. <b>OR</b> Account, order, or other proof. This will show that someone has the legal right to care for a person. Other proof can be legal forms that show someone can by law act for the member. Complete the boxes below:			
Legal representative for member (print full name)			How legal representative is related to member
Legal representative's street address	City	State	ZIP code
Signature			Date
X			
Please return the completed form to: Blue Cross Community Centennial PO Box Albuquerque, NM 87125			
For internal use only:			
Inquiry tracking number			

Here are samples of legal forms. These are used when a person needs someone else to make choices for them.

- **Health Care, General, or Durable Power of Attorney.** This form gives someone the legal power to act for you. This person can make health care choices for you. It might say this on the form: “to take charge of my person in the case of sickness of any kind.” It may also say this “and in general to do and act for me and in my name all that I might do if I am not there.”
- **Legal Guardianship.** This is when the court names someone to care for a person.
- **Conservatorship.** This happens when a judge names a person to be in charge. This would be when a person can’t make choices for him or herself.
- **Executor of estate.** This type of form would be used when the person who is being spoken for has died.



Member Authorization Form

This form must be filled out by a member. It allows a person or company to see the member's records. Please write in as much about yourself as you can. If you need help, see the letter that's with this form. It will show you how to fill out each part. Also, you can call the number on your member ID card.

PART A: MEMBER			
Member last name	Member first name	Middle initial	Member date of birth 
Member street address	City	State	ZIP code
Daytime phone number (with area code)	Member ID number (see member ID card)	Group number (see member ID card)	

PART B: PEOPLE OR COMPANIES WHO WILL GET MY RECORDS	
The people or companies listed and checked below have the right to see my records. (They must be 18 or older). Please check each box that applies. Write in first and last names.	
<input type="checkbox"/> My spouse (first and last name)	<input type="checkbox"/> My parents (If you are over 18, write in first and last names)
<input type="checkbox"/> My adult children (first and last names)	<input type="checkbox"/> Other (First and last name if you have it. This could be a person or the name of company. Also write what this person or company has to do with you.)

PART C: MY RECORDS	
I will let Blue Cross Community Centennial share the records below (check only one box):	
<input type="checkbox"/> <b>All my health records.</b> All my health records. This can be records about your health, a diagnosis (name of illness or health problem), claims, names of doctors and other health care providers. Records also can be about money (like billing and banking). Checking this box won't let others see sensitive (very personal) records unless I agree to it below. <b>OR</b>	
<input type="checkbox"/> <b>Only some records</b> (check all that apply to you)	
<input type="checkbox"/> Appeal <input type="checkbox"/> Benefits and coverage <input type="checkbox"/> Bills <input type="checkbox"/> Claims and payment <input type="checkbox"/> Diagnosis (name of illness or health problem) <input type="checkbox"/> Eligibility <input type="checkbox"/> Doctor and hospital <input type="checkbox"/> Doctor's records <input type="checkbox"/> Money areas	<input type="checkbox"/> Pre-certification and pre-authorization (for treatment approvals). This is when we give you an OK for a treatment. <input type="checkbox"/> Referral (when your main doctor says it's OK to see a special doctor for certain treatment) <input type="checkbox"/> Treatment <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Pharmacy <input type="checkbox"/> Other: _____
I also will let BCBSNM share this type of sensitive (very personal) records below. Check all boxes that apply to you.	
<input type="checkbox"/> <b>All sensitive records below</b> <b>OR</b>	
<input type="checkbox"/> <b>Just some records about topics checked below:</b>	
<input type="checkbox"/> Abortion <input type="checkbox"/> Abuse (sexual/physical/mental) <input type="checkbox"/> Alcohol and drug abuse* <input type="checkbox"/> Testing of genes <input type="checkbox"/> HIV or AIDS	<input type="checkbox"/> Being pregnant <input type="checkbox"/> Mental health <input type="checkbox"/> Sexual diseases passed on to others <input type="checkbox"/> Other: _____

\*I know that my alcohol and drug abuse records are protected under federal and state laws and rules. This form will keep these records private. No records can be given out without my saying so in writing. This is unless it says so in the laws and rules. I also know that I may take back the fact that I agreed to this at any time, or as stated below in Part E. I know that I cannot cancel this signed form after we have given out your health records.

**PART D: WHY YOU WANT YOUR RECORDS SHARED**

For the reasons shown on this form

**OR**

Special reason(s): \_\_\_\_\_

**PART E: REVIEW AND SIGN**

Once I sign and send in the form, it will be good for:

One year from the day I signed the form

**OR**

Before one year and on the date, event or reason shown

I have read each part of this form. I know, agree, and will let Blue Cross Community Centennial use and give out my records as I have stated above. I also know that I signed this form of my own free will. I know that I don't need to sign this form to get treatment or payment, or for signing up for or getting benefits.

I have the right to take back what I agreed to in this form at any time. I will tell Blue Cross Community Centennial in writing that I'm doing so.

I know that taking this back will not change any action taken before I do so. I also know that any records that a person or group gets (that I've agreed to) may be given out. If this happens, the records may no longer be protected under the HIPAA Privacy Rule.

Member signature (If member is a minor, parent's signature)

**X**

Date

You have the right to keep a copy of this form after you fill it out. Please make a copy for your records. Return this completed form in the envelope we sent you with this form.

**NAMED LEGAL PERSON OR GUARDIAN**

If there is a person who is signing for the member, (someone who takes care of the member), we need these forms filled out: A copy of a health care, general or Durable Power of Attorney.

**OR**

Provide a court order or other proof that shows that someone else has the legal right to care for a person. Other proof can be legal forms that show someone can by law act for the member. Complete the boxes below:

Legal representative for member (print full name)		Legal representative's relationship to member	
Legal representative's street address	City	State	ZIP code
Signature			Date

**Please return the completed form to:**

Blue Cross Community Centennial  
PO Box 660044  
Dallas, TX 75266-0044

For internal use only:

Inquiry tracking number

To ask for auxiliary aids and services or materials in other formats and languages at no cost, please call **1-866-689-1523** (TTY/TDD: **711**).

Blue Cross and Blue Shield of New Mexico complies with applicable federal civil rights laws and does not discriminate on the basis of health status or need for services or race, color, national origin, age, disability, sex, ancestry, spousal affiliation, sexual orientation and/or gender identity. Blue Cross and Blue Shield of New Mexico does not exclude people or treat them differently because of health status or need for services or race, color, national origin, age, disability, sex, ancestry, spousal affiliation, sexual orientation and/or gender identity.

Blue Cross and Blue Shield of New Mexico provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats and more)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that Blue Cross and Blue Shield of New Mexico has failed to provide these services or discriminated in another way on the basis of health status or need for services or race, color, national origin, age, disability, sex, ancestry, spousal affiliation, sexual orientation and/or gender identity, you can file a grievance with: Civil Rights Coordinator, Office of Civil Rights Coordinator, 300 E. Randolph St., 35th floor, Chicago, Illinois 60601, **1-855-664-7270**, TTY/TDD: **1-855-661-6965** or Fax: **1-855-661-6960**. You can file a grievance in person, by mail or fax. If you need help filing a grievance, a 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, D.C. 20201

**1-800-368-1019, 1-800-537-7697** (TDD)

Complaint forms are available at **<http://www.hhs.gov/ocr/office/file/index.html>**.



Para solicitar ayuda y servicios auxiliares o materiales en otros formatos e idiomas de manera gratuita, llame al **1-866-689-1523** (TTY/TDD: **711**).

Blue Cross and Blue Shield of New Mexico cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de estado de salud o necesidad de servicios médicos o raza, color, país de origen, edad, discapacidad, sexo, ascendencia, afiliación conyugal, orientación sexual o identidad de género. Blue Cross and Blue Shield of New Mexico no excluye a las personas ni las trata de manera diferente según su estado de salud o necesidad de servicios médicos o raza, color, país de origen, edad, discapacidad, sexo, ascendencia, afiliación conyugal, orientación sexual o identidad de género.

Blue Cross and Blue Shield of New Mexico proporciona:

- asistencia y servicios gratuitos a personas con discapacidad para que se comuniquen de manera eficaz con nosotros, como los siguientes:
  - intérpretes capacitados en lenguaje de señas;
  - información escrita en otros formatos (letra grande, audio y formatos electrónicos accesibles, entre otros).
- servicios lingüísticos gratuitos a personas cuya lengua materna no es el inglés, como los siguientes:
  - intérpretes capacitados;
  - información escrita en otros idiomas.

Si necesita estos servicios, comuníquese con el coordinador de derechos civiles.

Si cree que Blue Cross and Blue Shield of New Mexico no ha proporcionado estos servicios o ha discriminado de alguna otra manera por motivos de estado de salud o necesidad de servicios médicos o raza, color, país de origen, edad, discapacidad, sexo, ascendencia, afiliación conyugal, orientación sexual o identidad de género, puede presentar una inconformidad ante: Civil Rights Coordinator, Office of Civil Rights Coordinator, 300 E. Randolph St., 35th floor, Chicago, Illinois 60601, **1-855-664-7270**, TTY/TDD: **1-855-661-6965**, fax: **1-855-661-6960**. Puede presentar una inconformidad en persona o por correo postal o fax. Si necesita ayuda para presentar una inconformidad, un coordinador de derechos civiles estará a su disposición.

También puede presentar una queja de derechos civiles ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de EE. UU. de forma electrónica a través del portal de quejas de la Oficina de Derechos Civiles en **<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>** o por correo postal o teléfono a:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201

**1-800-368-1019, 1-800-537-7697** (TDD).

Formularios para presentar quejas disponibles en **<http://www.hhs.gov/ocr/office/file/index.html>**.



ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-710-6984 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-710-6984 (TTY: 711).

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, kojí' hódííłnih 1-855-710-6984 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-710-6984 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-710-6984 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-710-6984 (TTY: 711)。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-710-6984 (رقم هاتف الصم والبكم: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-710-6984 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-710-6984 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-710-6984 (TTY: 711) まで、お電話にてご連絡ください。

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-710-6984 (ATS: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-710-6984 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-710-6984 (телетайп: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।

1-855-710-6984 (TTY: 711) पर कॉल करें।

هجوٲ: رگا هب نابز سرافى وگتفگ مى دینک، تلابهست نابزى هب تروص ناگیار اربى امش مهارف مى دشاب. اب 1-855-710-6984 (TTY: 711) سامت دیریگب.

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-710-6984 (TTY: 711).