



AGENT AUTHORIZATION

Wellmark BlueCross BlueShield of Iowa
Wellmark Health Plan of Iowa, Inc.

Independent Licensees of the Blue Cross and Blue Shield Association

This form is used to authorize Wellmark to release protected health information to the applicant's Agent for the purpose of completing the application for insurance and pre-enrollment underwriting process.

Name of Applicant: _____ Date of Birth: _____

USE OR DISCLOSURE BEING AUTHORIZED

Entity Authorized to Disclose: Wellmark Blue Cross and Blue Shield of Iowa or Wellmark Health Plan of Iowa

Entity Authorized to Receive: Name of Agent: _____

Protected Health Information to be Disclosed and Purpose: Wellmark may disclose information concerning any past, present and future health care treatment or conditions as needed to complete the application for insurance or pre-enrollment underwriting process.

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

Prohibition on Redisclosure and Effect of Granting this Authorization: This form does not authorize the disclosure of medical information beyond the limits of the authorization. Where information has been disclosed from the records protected by Federal law for alcohol/drug abuse records or state law for mental health records, the Federal requirements (42 CFR Part 2) and state requirements (Iowa Code Chapter 228) prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. I understand that if the entity that receives the information requested is not covered by federal or state privacy laws, the information described above may be redisclosed and will no longer be protected by law.

EXPIRATION AND REVOCATION

Expiration: This authorization is in force until the pre-enrollment underwriting process and enrollment is complete, at which time it expires.

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to Wellmark at the address stated below. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation and, if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

INDIVIDUAL'S SIGNATURE

Specific Authorization for Release of Mental Health, Substance Abuse Treatment or Aids-Related Information: I authorize the release and disclosure of any and all personal health information, including specifically mental health information, substance abuse (drug or alcohol), and AIDS-related information, if applicable, and all claims information to the individual or entity named above as long as this authorization is in effect. I understand that I may inspect the mental health information disclosed.

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 my authorization of the use and/or disclosure of my protected health information, as described in this form. If this authorization involves the disclosure of mental health information, I acknowledge receipt of a copy of the authorization.

Signature: _____ **Date:** _____

A spouse or parent of an individual 18 years or older may NOT sign on behalf of the individual without appointment through a legal process.

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name Relationship to Patient

RETAIN A COPY FOR YOUR RECORDS