BlueCross BlueShield
BluePlus
of Minnesota
Independent licensees of the Blue Cross and Blue Shield Association

Authorization Cancellation

Please read these instructions carefully before completing this form.

When to Use this Form

Complete this form if you want to cancel an authorization to release information about you that is currently on file with Blue Cross and Blue Shield and Blue Plus. You may also cancel an authorization for an individual to act on your behalf.

Parents or a legal guardian may sign for a minor unless the minor is permitted under state law to consent to the treatment. In that case, the minor must sign the form.

How to Complete this Form

This form must be completed and signed by one of the following:

- The person whose authorization is on file
- The parent or legal guardian of the person whose authorization is on file except as listed above
- The personal representative of the person whose authorization is on file (e.g. power of attorney, conservator, executor)

To complete this form:

- Fill in the name, member identification, date of birth and group number of the person whose authorization is on file
- Fill in the type of information you'd like to discontinue from release
- Fill in the name of the person or organization you would like to stop from seeing your information
- Sign and date the form
- If you are not the person requesting the cancellation, state your relationship to that person

Mail this Form to

Blue Cross and Blue Shield of Minnesota and Blue Plus
P.O. Box 64560
St. Paul MN 55164-0560

This information is also available in other ways to people with disabilities by calling customer service at **(651) 662-8000** (voice), or **1-800-382-2000** (toll free).

For TTY: Call **(651) 662-8700**, or **1-888-878-0137** (TTY), or 711, or through the Minnesota Relay direct access numbers at **1-800-627-3529** (TTY, Voice, ASCII, Hearing Carry Over), or **1-877-627-3848** (Speech-to-Speech).

Hours: 7 a.m. to 8 p.m. Central Time, Monday through Friday

Attention: If you want free help translating this information, call the above number.
Atención: Si desea ayuda gratis para traducir esta información, llame al número que aparece arriba.

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Member Information (person requesting cancellation)

Member Name _____ Member ID _____
Date of Birth _____ Group Number _____

Cancellation Statement

I cancel my authorization to release the following information (Check all that apply)

- ☐ Address, date of birth, membership status
- ☐ Claim Information
- ☐ Premium Information
- ☐ Appeal Information
- ☐ Psychotherapy Notes

I cancel my authorization for _____ to release information to Blue Cross and Blue Shield and Blue Plus.

I cancel my authorization for Blue Cross and Blue Shield and Blue Plus to release information to:

Name _____
Address _____
Phone Number _____

I understand that my cancellation of this Authorization does not affect any release of information processed before I canceled it.

If my Authorization was a condition of my enrollment or claim(s) processing, I understand that my cancellation may cause Blue Cross and Blue Shield and Blue Plus to decline my enrollment or my claims because they do not have all the information they need.

Signature

_____ _____
Signature of Member Date

_____ _____
Signature of Parent or Personal Representative Date

If this request is by a personal representative on behalf of the Member, complete the following:

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

Note: You have a right to keep a copy of this notice after you sign it.