Empire BLUECROSS BLUESHIELD

po box 1407, church street station
new york, ny 10008-1407

AUTHORIZATION FOR RELEASE OF INFORMATION

SUBSCRIBER'S/PATIENT'S NAME:_____

SUBSCRIBER'S/PATIENT'S EMPIRE BLUECROSS BLUESHIELD IDENTIFICATION NUMBER:_____

I do hereby affirm that I am the above mentioned subscriber/patient or legally authorized representative of the above-mentioned subscriber/patient. I hereby authorize Empire BlueCross BlueShield to release claims, payment, eligibility, and benefit information to my representative,_____,
(Please print name of authorized representative.)

and to allow my representative to update my address and/or primary care physician change (if applicable). This authorization is valid from the date signed until:

☐ _____ (enter date)

☐ Indefinitely

Limitations: _____

_____

_____

_____

_____ _____
Signature of Subscriber/Patient Date Signature of Representative Date

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