Interoperability Opt-Out Form

CareFirst
Family of health care plans

You may authorize your insurer, CareFirst BlueCross BlueShield ("CareFirst"), in writing to opt out of sharing your Protected Health information with your treating provider(s) via the Provider Access API by completing and submitting this authorization.

AUTHORIZATION OF INFORMATION TO OPT OUT OF DATA SHARING

Name of Health Insurance Plan:

◯ CareFirst BlueCross BlueShield Medicare Advantage ◯ CareFirst BlueCross BlueShield

Member Last Name, First Name, MI		Member ID
Mailing Address		
City	State	ZIP Code
Phone Number	Date of Birth (mm/dd/yyyy)	

DISCLOSURE

If you choose to complete this form and submit it to the CareFirst Privacy Office, you are requesting that your Protected Health information (i.e., Adjudicated Claims, Prior Authorization Status, Clinical/Encounter Data and Sensitive Data) not to be shared with your treating provider(s) via the Provider Access API solely for the purposes of enhancing or coordinating your care or to assist your treating provider(s) in making clinical decisions about your care.

The decision not to share your data with your treating provider(s) via the Provider Access API will remain in effect unless:

- You modify your preferences and elect to opt in to data sharing

Please understand that if you submit this form your physician and your treating healthcare providers will not have access to the Provider Access API that CareFirst may make available to the aid in patient care.

CONFIRMATION

I understand that by signing this form, I am confirming my decision to opt out of the sharing of my Protected Health information via the Provider Access API. I also understand that this will not affect any actions taken by my health plan administrator before this request becomes effective.

Full Member Name (printed)	
Signature of Member or Parent/Guardian (if applicable)	Date

This opt-out request will take effect within 60 days of receipt by CareFirst.

If the person signing this form is not the member, or the parent/guardian of a dependent under the age of 18, you must attach a full copy of the official document indicating your legal authority to sign on behalf of the member (i.e., Power of Attorney, Court Assigned Guardian, Personal Representative, etc.).

Please submit all written requests to the address below:

CareFirst BlueCross BlueShield Privacy Office
P.O. Box 14858
Lexington, KY 40512

Fax: **410-505-6492**

Email: **Privacy.office@carefirst.com**

Please keep a record of this form. Will we provide you with a signed copy upon request.

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