



Please fill out this form and give us the names of any business associates (such as, Third Party Administrators, auditors, billing service companies, etc.) to whom you, as a health care provider want us to disclose protected health information. Also list any conditions or limitations that apply to our disclosure of protected health information to them. If you list no conditions or limitations, then we will give them all of the protected health information they request from us.

The undersigned hereby authorizes Blue Cross and Blue Shield of Alabama to disclose protected health information to the following business associates (BA) and third party administrators (TPA).

<i>BAs/TPAs</i>	<i>CONDITIONS/LIMITATIONS</i>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

The undersigned understands that this authorization will remain in effect until Blue Cross and Blue Shield of Alabama receives notification that the aforementioned authorization has been revoked or otherwise amended. The undersigned also agrees to notify Blue Cross and Blue Shield of Alabama in a timely manner if the list changes.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

For the Health Care Provider \_\_\_\_\_

Unless otherwise noted in conditions/limitations, each BA/TPA noted will be considered the Business Associate of the provider or entity named as the Health Care Provider above.

By \_\_\_\_\_

Its \_\_\_\_\_

*Please complete, sign and return this form to Blue Cross and Blue Shield of Alabama. If you do not return this form, then we will not disclose protected health information to your business associates and third party administrators until you authorize us to do so in writing.*