Anthem

INDIVIDUAL AUTHORIZATION

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

Instructions: The individual member who is requesting the release of his or her information to another person or Organization/Entity must complete this form in its entirety and include as much information as possible.

Individual Last Name	Individual First Name	Middle Initial	Group ID Number
Individual ID Number (From Member ID Card)	**Social Security Number (optional)**	**Date of Birth (mm/dd/yyyy)**	**Daytime Telephone (with Area Code)**
Individual Street Address	**City**	**State**	**Zip Code**

Part A: I authorize the following person or Organization/Entity to disclose my information:

Anthem Blue Cross and Blue Shield and its affiliates and agents

Part B: I authorize the following person or Organization/Entity to receive my information (the person receiving the information must be 18 years of age or older):

Andrew Kaelin, Robert Bragan or Jenifer Siegel

Relationship to the individual Benefits Managers

Part C: I authorize the following information to be used or disclosed on my behalf **(check one block):**

☒ **All my information** including health (e.g. diagnosis, claims, provider) and financial information (e.g. premium information, checking account) may be disclosed

OR

☐ **Only limited information** may be disclosed (check all applicable blocks below)

Limited Information

- ☐ Appeal
- ☐ Benefits & coverage
- ☐ Billing
- ☐ Claims & payment
- ☐ Diagnosis & procedure
- ☐ Eligibility & enrollment
- ☐ Financial
- ☐ Medical records (excludes psychotherapy notes*)
- ☐ Physician & hospital
- ☐ Pre-certification & pre-authorization
- ☐ Referral
- ☐ Treatment
- ☐ Dental
- ☐ Vision
- ☐ Pharmacy
- ☐ Mental Health
- ☐ Other: _____

I authorize the release of the following types of sensitive information (check all blocks that apply):

☐ Abortion	☐ Maternity
☐ Abuse (sexual/physical/mental)	☐ Mental health
☐ Alcohol/substance abuse	☐ Sexually transmitted or other communicable diseases
☐ Genetic testing	
☐ HIV or AIDS	☐ Other: _____

Part D: The purpose of my authorization is (check one block):

☐ To disclose the information at my request
☒ For the following purposes: Claims Question / Billing Question

Part E: Expiration Date. If not previously revoked, this authorization will terminate on the earliest of the following dates:

- the date my coverage ends (only if disclosure requested by insurance company); or
- one year from the signature date below; or
- upon the following date, event or condition (within the one year time frame):

_____

Part F: **I have read the contents of this authorization and understand and agree to the use and disclosure of my information as specified above.** I also understand this authorization is voluntary and that the person listed in Part A will not condition my treatment, payment, or enrollment or eligibility for benefits on signing this authorization.

I have the right to revoke this authorization at any time by giving written notice of my revocation to the person listed in Part A. I understand that my revocation will not affect any action taken before my written revocation notice is received. I also understand that information disclosed may be subject to re-disclosure by the recipient in which case it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this authorization.

X _____ **Date**

X _____ **Individual Signature**

Designated Legal Representative / Guardian

If this form is signed by a legal representative / guardian on behalf of the individual, please complete the following. A copy of a Health Care Power of Attorney, a court order or other documentation establishing custody or other legal documentation demonstrating the authority of the legal representative to act on the individual's behalf must be attached.

Legal representative (print full name): _____

Legal relationship to individual: _____

Signature: _____ **Date:** _____

*Note: **This form cannot be used for psychotherapy notes. If you seek to authorize the use or disclosure of psychotherapy notes, then you will need to do so using a separate form.**

Please keep a copy of this form for your records and return the completed form to:

Anthem Blue Cross and Blue Shield
HIPAA Privacy Team
Post Office Box 37110
Louisville, KY 40233-7110