



INDIVIDUAL AUTHORIZATION FORM

Correspondence Team

Note: Your enrollment in a health plan, eligibility for benefits, processing and payment of claims, or treatment is not conditioned on giving this authorization.

Section A: The Individual's Information: about the individual whose information will be released.

Only One Member Per Form. Additional Members Must be Completed on a Separate Form.

Date-of-Birth (MM/DD/YYYY): ____/____/____

Name: _____

Address: _____

Social Security Number: _____-_____-_____

Member ID (on ID card – include all letters & numbers): _____

Group Number (on ID card – include all letters & numbers): _____

Section B: Who Can Release the Information: the person/company who is allowed to release the information.

- Anthem Blue Cross and Blue Shield and its Business Associates

Section C: Who Can Receive the Information: the person/company/agency or facility who is allowed to receive the information. Please select only one, and include the address.

Name (if a person): _____

Address: _____

Company, Agency or Facility Name (if applicable): _____

Name of Contact at Company, Agency or Facility: _____

Address: _____

Section D: What Information is Being Released: Indicate what information you are authorizing to be released (check all that apply). If the general categories below do not suffice, please describe in detail the kind of information you want released, and if applicable the date(s) of the information (e.g. claims for the last 6 months; premium payment record for April, 2003).

- | | | |
|---|---|---|
| <input type="checkbox"/> Claims/Claims Status | <input type="checkbox"/> Enrollment | <input type="checkbox"/> Benefit/Coverage/Eligibility |
| <input type="checkbox"/> Referrals | <input type="checkbox"/> Physician/hospital information | <input type="checkbox"/> Appeals |
| <input type="checkbox"/> PCP/Provider Information | <input type="checkbox"/> Premium Payment/Billing | <input type="checkbox"/> Financial |
| <input type="checkbox"/> Diagnosis/Procedure | <input type="checkbox"/> Pre-Certification/ Pre-Authorization | <input type="checkbox"/> Medical Records (excludes Psychotherapy notes) |
- Other, please specify: _____

Dates of the information (if applicable): ____/____/____ to ____/____/____ or _____

In addition, if you agree that the following types of records may be released, please indicate so by checking the appropriate boxes:

- | | | |
|--|--|---|
| <input type="checkbox"/> HIV or AIDS | <input type="checkbox"/> Alcohol/substance abuse | <input type="checkbox"/> Maternity |
| <input type="checkbox"/> Sexually transmitted or other communicable diseases | <input type="checkbox"/> Abortion | <input type="checkbox"/> Sexual/physical/mental abuse |

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*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. Because of the sensitive nature of psychotherapy notes, your authorization to use or disclose psychotherapy notes cannot be combined with an authorization to release any other type of protected health information.

Section E: Purpose of the release of information (check only one)

- At the request of the individual; or
- If not requested by the individual, state the purpose of the release of the information:

Section F: Expiration Date:

If not previously revoked, this authorization will terminate on the earliest of the following dates:

- (1) the date the individual’s coverage ends (only if disclosure requested by insurance company); or
- (2) one year from the signature date below; or
- (3) upon the following date, event or condition: _____

*The party identified in Section B must be notified **in writing** of the event/condition to cancel authorization.*

NOTE: This form is only good for one year, or less, depending on the option you choose. A new form will need to be completed within one year from the date of signing (or sooner).

Section G: Signature:

A copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original. I understand that if this information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by federal privacy regulations, my information described above may be re-disclosed by the recipient and no longer protected by federal privacy regulations. I have the right to cancel this release of information/authorization at any time, except to the extent that the person/company has already taken action on the disclosure provisions contained in this document. If I choose to cancel the release of information/authorization, I must notify the person/company identified in Section B **in writing** that I request a cancellation of this release of information/authorization.

(Printed name of adult member, parent on behalf of minor or legal representative)

Date: _____

(Signature of adult member, parent on behalf of minor, as applicable, and date)

Date: _____

(Signature of legal representative, if applicable, and date)

If a legal representative signs on behalf of the individual, a copy of the legal representative’s authority must be attached to this form (e.g. Health Care Power of Attorney, Executor/Administrator of an estate)

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YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION