INDIVIDUAL AUTHORIZATION

Instructions: Please complete the following information exactly as it appears on your member Identification (ID) Card. Complete the form in its entirety and include as much information as possible. If necessary, call the number listed on the back of your member ID card for assistance.

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 types of people to disclose my information:

Anthem Blue Cross and its affiliates and agents

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

Relationship to the individual_____

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
- ☐ Physician & hospital
- ☐ Pre-certification & pre-authorization

☐ Billing	☐ Referral
☐ Claims & payment	☐ Treatment
☐ Diagnosis & procedure	☐ Dental
☐ Eligibility & enrollment	☐ Vision
☐ Financial	☐ Pharmacy
☐ Medical records (excludes psychotherapy notes*)	☐ Behavioral Health
	☐ Other: _____

I do not 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	☐ Other: _____
☐ HIV or AIDS	

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

☐ To disclose the information at my request
☐ For the following purposes: _____

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.

Date **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.*