



**INDIVIDUAL AUTHORIZATION**

**(for release of PHI from Provider to Company)**

**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: 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.

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

**Part A:** I authorize the following person or types of people to **disclose** my information:

Name of Provider (i.e. physician, hospital):

Relationship to the individual \_\_\_\_\_

**Part B:** I authorize the following company and its affiliates and agents to **receive** my information.

Anthem Blue Cross and Blue Shield and its affiliates and agents

**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)

<b>Limited Information</b>	
<input type="checkbox"/> Appeal	<input type="checkbox"/> Physician & hospital
<input type="checkbox"/> Benefits & coverage	<input type="checkbox"/> Pre-certification & pre-authorization
<input type="checkbox"/> Billing	<input type="checkbox"/> Referral
<input type="checkbox"/> Claims & payment	<input type="checkbox"/> Treatment
<input type="checkbox"/> Diagnosis & procedure	<input type="checkbox"/> Dental
<input type="checkbox"/> Eligibility & enrollment	<input type="checkbox"/> Vision
<input type="checkbox"/> Financial	<input type="checkbox"/> Pharmacy
<input type="checkbox"/> Medical records (excludes psychotherapy notes*)	<input type="checkbox"/> Behavioral Health
	<input type="checkbox"/> Other: _____



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

<input type="checkbox"/> Abortion	<input type="checkbox"/> Maternity
<input type="checkbox"/> Abuse (sexual/physical/mental)	<input type="checkbox"/> Mental health
<input type="checkbox"/> Alcohol/substance abuse	<input type="checkbox"/> Sexually transmitted or other communicable diseases
<input type="checkbox"/> Genetic testing	<input type="checkbox"/> Other: _____
<input type="checkbox"/> HIV or AIDS	

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

<input type="checkbox"/> To disclose the information at my request
<input type="checkbox"/> 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.*

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

**Anthem Blue Cross and Blue Shield  
P.O. Box 27401  
Mail Point VA 4003-M000  
Richmond, VA 23279-7401**

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. In Connecticut: Anthem Health Plans, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In most of Missouri: RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. In Ohio: Community Insurance Company in Ohio. In Virginia: Anthem Health Plans of Virginia, Inc. (serving Virginia excluding the city of Fairfax, the town of Vienna and the area east of State Route 123.). In Wisconsin: Blue Cross Blue Shield of Wisconsin ("BCBSWi") underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation ("Compcare") underwrites or administers the HMO policies; and Compcare and BCBSWi collectively underwrite or administer the POS policies. Independent licensees of the Blue Cross Blue Shield Association. © ANTHEM is a registered trademark. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.