Member Authorization Form



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.

This form is to be filled out by a member if there is a request to release the member's health information to another person or company. Please include as much information as you can.

Part A: Member information

Member last name		Member first name		Middle initial	Member date of birth (MM/DD/YYYY)
Member street address		City		State	ZIP code
Daytime telephone number (with area code)	Cell/mobile teleph (with area code)	one number	Identification number (see identification card)	Group n (see ide	umber entification card)

Part B: Person or company who will receive this information

The following people or companies have the right to receive my information. (They must be 18 years of age or older). Please enter first and last name. By entering first/last name below that person may receive my information.

My spouse (enter first and last name)	My parents (if you are over 18 – enter first and last name[s])
My domestic partner (enter first and last name)	My insurance broker or agent (enter the name of the company and first and last name, if you have it)
My adult children (enter first and last name[s])	Other (enter first and last name [if you have it], name of company, and how it's related to you)

Part C: Information that can be released

I allow the following information to be used or Check only one box .	released by Anthem Blue Cross and Blue Shie	ld (Anthem) on my behalf:
and financial information (like billing and ba	a diagnosis (name of illness or condition), clain nking). This doesn't include sensitive informati	ns, doctors and other health care providers on (see below) unless it is approved below.
OR Only limited information may be released	d (check all boxes below that apply to you).	
 Appeal Benefits and coverage Billing Claims and payment Diagnosis (name of illness or condition) and procedure (treatment) 	 Doctor and hospital Eligibility and enrollment Financial Medical records Pre-certification and pre-authorization (for treatment approvals) 	 □ Referral □ Treatment □ Dental □ Vision □ Pharmacy □ Other:
I also approve the release of the following type	·	all boxes that apply to you):
□ Abortion □ Abuse (sexual/physical/mental) □ Substance use disorder ^{1,2}	□ Genetic testing □ HIV or AIDS □ Maternity	 ☐ Mental health ☐ Sexually transmitted illness ☐ Other:
1 Specify time period of records to be disclose Description of records that may be disclosed	ed: 1:	
2 Unless I specify otherwise on this form, I inter Anthem about me. I understand that my subs laws and regulations and cannot be disclosed regulations. I also understand that I may reve I cannot cancel this approval when this form	end this disclosure to include all substance us stance use disorder records are protected un d without my written consent unless otherwis oke (or cancel) this approval at any time, or a has already been used to disclose informatic	se disorder records maintained by der Federal and State confidentiality se provided for in the laws and is described in Part E. I understand that on.
Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Met Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthe HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and H Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba H Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and Corporation (WCIC). Compcare underwrites or administers HMO or POS policies; WCIC underwrites or a 199331.MURNABS 9/18	tical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Hea m Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightD MO benefits underwritten by HMO Missouri, Inc. R1 and certain affiliates only provide administr O Nevada. In New Hangshire: Anthem Health Plans or New Hangshire, Inc. HMO Jans are admir Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of infermity policies and underwritten blue U thrank the New Kine Shield in Virginia, and Eservice area is all of diministers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue S	Ith Plans, Inc. In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. In Indiana HOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALD), and ative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky istered by Anthem Health Plans of New Hamgshire, Inc. and underwritten by Matthew Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route are Health Services Insurance Corporation (Compare) or Visconsin Collaborative Insurant hield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc. 1 of

Part D: Purpose of this approval – Check only one box.

 \Box To give out the information as shown on this form.

OR \Box For this reason(s):

Part E: Date your approval expires - Check only one box.

If this document was not already withdrawn, this approval will end on the earliest of the following dates: \Box one way from the signature data in Port 5.

□ One year from the signature date in Part F. **OR**

Earlier than one year and upon the date, event or condition described below:

Part F: Review and approval

I have read the contents of this form. I understand, agree, and allow Anthem to the use and release of my information as I have stated above or as required by applicable law. I also understand that signing this form is of my own free will. I understand that Anthem does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits.

I have the right to withdraw this approval at any time by giving written notice of my withdrawal to Anthem. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Member signature or Designated Legal Representative/Guardian signature			Date (MM/DD/YYYY)				
X							

Designated Legal Representative/Guardian -

Complete this section only if you have documentation supporting Legal Representation.

If this form is signed by someone other than the member or parent, such as a personal representative, legal representative or guardian on behalf of the member, please submit the following:

- A copy of a health care, general or Durable Power of Attorney.
- OR
- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf.

Please complete the following:

Legal representative (print full name)		Legal relationship to member				
Legal representative street address	City		State	ZIP code		
Signature X		Da	ite (MM	/DD/YYYY)		

Please return the completed form to:

Anthem Blue Cross and Blue Shield

Be sure to keep a copy of this form for your records.

For recipient of substance use disorder information

This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any patient with a diagnosis of substance use disorder.