INDIVIDUAL AUTHORIZATION FORM

Please complete this form and mail to:
Anthem Blue Cross and Blue Shield
Attn: IN0201-D446
PO Box 37180
Louisville, KY 40233

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.

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

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

☐ Other: ____

Section C: Who Can Receive the Information: the person/company/agency or facility who is allowed to receive the information.

Name: ____

Address: ____

Company Name (if applicable): ____

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)

- ❑ Claims/Claims Status
- ❑ Referrals
- ❑ PCP/Provider Information
- ❑ Diagnosis/Procedure
- ❑ Enrollment
- ❑ Physician/hospital information
- ❑ Premium Payment/Billing
- ❑ Pre-Certification/ Pre-Authorization
- ❑ Benefit/Coverage/Eligibility
- ❑ Appeals
- ❑ Financial
- ❑ 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:

- ❑ Psychotherapy records*
- ❑ HIV or AIDS
- ❑ Sexually transmitted or other communicable diseases
- ❑ Mental health
- ❑ Alcohol/substance abuse
- ❑ Abortion
- ❑ Genetic testing
- ❑ Maternity
- ❑ Sexual/physical/mental abuse

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.*

Section G: Signature:

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

Signature: ____ Date: ______________________

If this authorization is signed by a personal representative on behalf of the individual, complete the following and attach a copy of the representative's authority to this form (e.g. copy of Health Care Power of Attorney, Executor/Administrator of an estate):

Personal Representative's Name: ____

Relationship to Individual: ____

**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.*