

If you have any questions, please feel free to call us at the customer service number on your member identification card.

Please read the following for help completing page one of the form.

## PART A: MEMBER INFORMATION

This section applies to the member who is asking for the release of his or her information to another person or company.

- Print your last name, first name, and middle initial
- Write your date of birth in this format: mm/dd/yyyy. (If you were born on October 5, 1960, you would write 10/05/1960.)
- Write your full street address, city, state, and ZIP code
- Write your daytime phone number (including area code)

### Identification number

You will find this number on your member identification card

### • Group number

You will find this number on your member identification card. If your identification card does not have a group number leave this blank.

### PART B: PERSON OR COMPANY WHO WILL RECEIVE THIS INFORMATION

- Check the box that applies to you. Write the full name of the person or company that you want us to give your information to. Please don't use a general term like "my daughter" or "my son" as it will not be accepted. You need to be specific.
- If you check "Other," give the first and last name (if available), the name of the company (if applicable), and how they relate to you.

### PART C: INFORMATION THAT CAN BE RELEASED

This section tells us what information you would like us to release: all or just some.

- For "all of your information," check the first box.
- For "limited information," check the second box and the boxes that apply to you.
- Some topics may be very personal or sensitive to you. If you wish to approve the release of this type of information, check the box(es) that apply to you.

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al cliente que aparece al dorso de su tarje	ta de iden	itificación o en o	el folleto de inscripción.			
This form is to be filled out by a member if t Please include as much information as you		request to relea	se the member's health i	nformatio	on to ano	ther person or company
PART A: MEMBER INFORMATION						
Member last name		Member first na	me		Aiddle nitial	Member date of birth
Member street address		City		S	State	ZIP code
Daytime telephone number (with area code)	Identif	fication number ( 5	see identification card)	Group nur	nber (see	e identification card)
PART B: PERSON OR COMPANY WHO WI	LL RECEIV	E THIS INFORM	ATION			Ŭ
The following people or companies have t each box that applies and enter first and			formation. (They must t	oe 18 yea	rs of age	e or older). Please cheo
My spouse (enter first and last name)			My parents (if you a	re over 18	8 - enter 1	first and last name[s])
My domestic partner (enter first and las	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 na	ime[s])		Other (enter first an and how it's related	d last nam	e (if you	have it], name of compa
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PART C: INFORMATION THAT CAN BE REL	FASED			8	)	
PART C: INFORMATION THAT CAN BE REI Lallow the following information to be us		ased by Anthem	Blue Cross on my beha	8 If (check	only one	: hox):
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Please read the following for help completing page two of the form.

## PART D: PURPOSE OF THIS APPROVAL

This section tells us the reason you've asked for the release of your information.

- Check the first box to let us know to give out this information as shown on this form.
- Check the second box for a specific reason. An example might be to settle a life insurance claim.

### PART E: DATE YOUR APPROVAL EXPIRES

You have two choices of when you would like this approval to end.

- Check the first box for the standard one-year that it will end.
- Check the second box for an earlier date (other than one year), and give the date you wish this approval to end.

Your authorization/approval can't be granted for more than one year.

## PART F: REVIEW AND APPROVAL

- Sign your name and put the date on the form. Your name and signature *must* match the information in Part A.
- If you are signing this form on behalf of another person, or if you have Power of Attorney for health care, or are a legal guardian/conservator you must do the following:
  - You must complete the Designated Legal Representative/Guardian section.
  - You must also provide us with a copy of the legal document showing that you are approved and include it with this form.

Examples of legal documents:

- Health Care, General or Durable Power of Attorney. This document gives someone you trust the legal power to act on your behalf and make health care decisions for you.
- Legal Guardianship. This is when the court appoints someone to care for another person.
- **Conservatorship**. This happens when a judge appoints a responsible person to make decisions for someone who can't make responsible decisions for him/herself.
- Executor of estate. This type of document would be used when the person who is being represented has died.

	n as shown on this form			
OR □ For this reason(s):				
PART E: DATE YOUR APPROV	VAL EXPIRES			
If this document was not alre	eady withdrawn, this app	proval will end on the earlie	est of the following dates:	
🗆 One year from the signatu	ire date in Part F		-	
OR Earlier than one year and u	upon the date, event or c	condition described below		
PART F: REVIEW AND APPRO				
I have stated above. I also ur	nderstand that signing th	is form is of my own free	ue Cross to the use and releas will. I understand that Anthem r for enrollment or being eligib	Blue Cross does not
that my withdrawing this app	proval will not affect any son or group who receive	action taken before I do s	of my withdrawal to Anthem Bl to. I also understand that infor y no longer be protected under	mation that's releas
Member signature or Designation <b>X</b>	ed Legal Representative/G	uardian signature		Date
DESIGNATED LEGAL REPRESE		6	ersonal representative, legal r	
representative to act of Please complete the following	ng:			
	0		Legal relationship to	member
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Please complete the followin Legal representative (print full Legal representative street add Signature X Please return the completed Anthem Blue Cross Be sure to keep a copy of th FOR RECIPIENT OF SUBSTAND This information has been di Records rules (42 CFP part 2 disclosure is expressly permi part 2. A general authorizati	iress if form to: is form for your records be ABUSE INFORMATION sclosed to you from reco ). The Federal rules proh titted by the written cons on for the release of mer	s. rds protected by Federal ibit you from making any f ent of the person to whon lical or other information i	Confidentiality of Alcohol or Dr urther disclosure of this inform it pertains or as otherwise ps NOT sufficient for this purpo	State ZIP code

# **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 the Please include as much information as you car		request to releas	e the member's health	informat	ion to and	other person or company.	
PART A: MEMBER INFORMATION							
Member last name	Member first nan		ne		Middle initial	Member date of birth	
Member street address		City			State	ZIP code	
Daytime telephone number (with area code)	Identi	fication number (s	ee identification card)	Group ni	umber (sei	e identification card)	
PART B: PERSON OR COMPANY WHO WILL The following people or companies have the each box that applies and enter first and las	e right	to receive my inf		be 18 ye	ars of ag	e or older). Please check	
☐ My spouse (enter first and last name)			□ My parents (if you are over 18 - enter first and last name[s])				
<b>My domestic partner</b> (enter first and last name)		☐ <b>My insurance broker or agent</b> (enter the name of the company and first and last name, if you have it)					
□ <b>My adult children</b> (enter first and last name[s])			<b>Other</b> (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 RELEA I allow the following information to be used		ased by Anthem	Blue Cross on my beba	alf (choc	k only on	a hov).	
All my information. This can include he providers and financial information (lik approved below. OR	ealth, a e billin	diagnosis (name g and banking).	e of illness or condition This doesn't include se	n), claims nsitive ir	s, doctors	and other health care	
<b>Only limited information</b> may be released	sed (cl						
<ul> <li>Appeal</li> <li>Benefits and coverage</li> <li>Billing</li> <li>Claims and payment</li> <li>Diagnosis (name of illness or condition) and procedure (treatment)</li> </ul>		Eligibility and e Financial Medical records Doctor and hos Pre-certification (for treatment)	s pital n and pre-authorizatior	□ Tr □ Do □ Vi n □ Pt	eferral eatment ental sion narmacy ther:		
I also approve the release of the following types of sensitive information by Anthem Blue Cross (check all boxes that apply to you): All sensitive information OR Just information about topics checked below							
□ Abortion □ Abuse (sexual/physical/mental) □ Alcohol/substance abuse **		] Genetic testing ] HIV or AIDS ] Maternity		🗆 Se	ental hea exually tra ther:	lth ansmitted illness	
** I understand that my alcohol/substance abust be disclosed without my written consent unlet (or cancel) this approval at any time, or as de already been used to disclose information.	ss othe	erwise provided for	r in the laws and regulati	ions. I als	o understa	and that I may revoke	
Anthem Blu	ie Cross is the	trade name of Blue Cross of Califor	nia. Independent licensee of the Blue Cross Asso	ociation.			

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

 $\Box$  For this reason(s):

# PART E: DATE YOUR APPROVAL EXPIRES

If this document was not already withdrawn, this approval will end on the earliest of the following dates:

 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 Blue Cross to the use and release of my information as I have stated above. I also understand that signing this form is of my own free will. I understand that Anthem Blue Cross 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 Blue Cross. 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

# Х

# DESIGNATED LEGAL REPRESENTATIVE/GUARDIAN

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 mer	nber	
Legal representative street address	City		State	ZIP code
Signature <b>X</b>			Da	te

# Please return the completed form to:

Anthem Blue Cross

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

### FOR RECIPIENT OF SUBSTANCE ABUSE INFORMATION

This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFP 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 alcohol or drug abuse patient.

For internal use only:	Inquiry tracking number
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