

Contract/Member ID #: _____ Member's Name: _____
(please include all letters and numbers)



Individual Authorization Form

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

Section A: The Individual's Information: about the individual whose information will be released. Please list only one member per form. Use separate forms for additional members.

Name: _____
Contract/Member ID # (please include all letters and numbers): _____
Address: _____
Group Number (on your ID card – include all letters and numbers): _____
Date-of-Birth (MM/DD/YYYY): ____/____/_____
Social Security Number: _____-_____-_____

Section B: Who Can Release the Information: the person/company who is allowed to release the information. Please select only one, and include the address.

The following person/company is allowed to release the information identified in Section D below:

Anthem Blue Cross and Blue Shield and its Business Associates
 Maine Partners Health Plan and its Business Associates
 Other _____
Address: _____

Section C: Who Can Receive the Information: the person/company/agency or facility who is allowed to receive the information. Please select only one, and include the address.

The following person, company, agency, or facility is allowed to receive the information requested:

Name: _____
Address: _____
 Company, Agency or Facility Name (if applicable): _____
Name of Contact at Company, Agency or Facility: _____
Address: _____

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; premium payment record for April, 2003).

Claims/Claims Status Premium Payment/Billing
 Enrollment Financial
 Benefit/Coverage/Eligibility Diagnosis/Procedure
 Referrals Physician hospital information
 Pre-Certification/Pre-Authorization Medical Records (excludes Psychotherapy notes)
 Appeals Other, please specify:
 PCP/Provider Information
 Dates of the information (if applicable): ____/____/____ to ____/____/____ or _____

YOU ARE ENTITLED TO A COPY OF THIS REQUEST

Contract/Member ID #: _____ **Member's Name:** _____
(please include all letters and numbers)

In addition, if you agree that the following types of information may be released, please indicate so by checking the appropriate boxes:

- | | |
|--|--|
| <input type="checkbox"/> Psychotherapy records* | <input type="checkbox"/> Maternity records |
| <input type="checkbox"/> Mental health records | <input type="checkbox"/> Sexually transmitted or other communicable diseases |
| <input type="checkbox"/> Genetic testing records | <input type="checkbox"/> Abortion |
| <input type="checkbox"/> HIV or AIDS records | <input type="checkbox"/> Sexual/physical/mental abuse |
| <input type="checkbox"/> Alcohol/substance abuse records | |

***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.

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; 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

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.

(Printed name of adult member, parent on behalf of minor or legal representative)

Date: _____

(Signature of adult member, parent on behalf of minor, as applicable, and date)

Date: _____

(Signature of legal representative, if applicable, and date)

If a legal representative signs on behalf of the individual, a copy of the legal representative's authority must be attached to this form (for example: Health Care Power of Attorney, Executor/Administrator of an estate)

Please complete this form and mail to:

Anthem Blue Cross and Blue Shield
Attention: Authorization
PO Box 687
North Haven CT 06473