

If not requested by the individual, state the purpose of the release of the information:

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: _____

(If an event or condition is specified, the company must be notified in writing of the event or condition for revocation to be effective)

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. This authorization is subject to revocation at any time upon written notice to the person/company specified above except to the extent that the person/company has already taken action on the disclosure provisions contained in this document.

_____ **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.

Please complete this form and mail to:

Anthem Blue Cross and Blue Shield
HIPAA Privacy Team
OH Large Group Customer Service
P.O. Box 37200
Louisville, KY 40233-7200

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION

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