Anthem

[Date]
Member ID: [Member ID number]

**We need your OK before we can give out your records to others.**
**Just fill out and sign this form.**

Dear Member:

Before we can give out your records, we need you to fill out the form that's with this letter. Then send it back to us. This form will let us know who we can give your records to.

**The form will be good for one year from the date you sign it. This is unless you ask for it to end sooner.**

Please be sure to fill out the whole form. Keep a copy for your records. Please don't change the form or leave things out. If there are problems, or if we have questions, we'll send you a letter or call you.

Once we get your signed form, we will process it quickly. If you have any questions, call Member Services at 844-912-0938 (TTY 711) Monday through Friday, from 7 a.m. to 8 p.m. Eastern time and ask to speak to the Member Privacy Unit.

Sincerely,

Member Privacy Unit
Anthem Blue Cross and Blue Shield

Enclosures: Nondiscrimination notice
Get help in another language

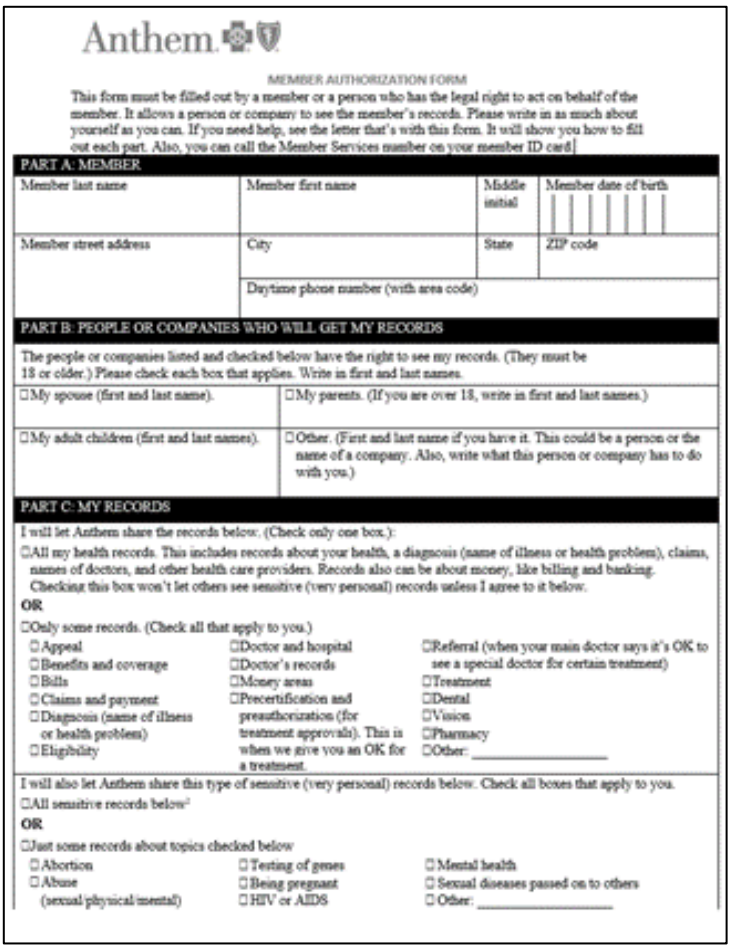
**anthem.com/oh/medicaid**

1038596OHMENABS 01/22

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

**PART A: Member**

1. Print your last name, first name, and the first letter of your middle name.
2. Write your date of birth like this: mm/dd/yyyy. So if you were born on October 5, 1960, you would write 10/05/1960.
3. Write your full street address, city, state, and ZIP code.
4. Write a daytime phone number (including area code) where you can be reached.



Anthem

MEMBER AUTHORIZATION FORM

This form must be filled out by a member or a person who has the legal right to act on behalf of the member. It allows a person or company to see the member's records. Please write in as much about yourself as you can. If you need help, see the letter that's with this form. It will show you how to fill out each part. Also, you can call the Member Services number on your member ID card.

PART A: MEMBER

| Member last name | Member first name | Middle initial | Member date of birth |
|---|---|---|---|
| Member street address | City | State | ZIP code |
| | Daytime phone number (with area code) | | |

PART B: PEOPLE OR COMPANIES WHO WILL GET MY RECORDS

The people or companies listed and checked below have the right to see my records. (They must be 18 or older.) Please check each box that applies. Write in first and last names.

| | |
|---|---|
| ☐My spouse (first and last name). | ☐My parents. (If you are over 18, write in first and last names.) |
| ☐My adult children (first and last names). | ☐Other. (First and last name if you have it. This could be a person or the name of a company. Also, write what this person or company has to do with you.) |

PART C: MY RECORDS

I will let Anthem share the records below: (Check only one box.):

☐All my health records. This includes records about your health, a diagnosis (name of illness or health problem), claims, names of doctors, and other health care providers. Records also can be about money, like billing and banking. Checking this box won't let others see sensitive (very personal) records unless I agree to it below.

OR

☐Only some records. (Check all that apply to you.)

| | | |
|---|---|---|
| ☐Appeal | ☐Doctor and hospital | ☐Referral (when your main doctor says it's OK to see a special doctor for certain treatment) |
| ☐Benefits and coverage | ☐Doctor's records | |
| ☐Bills | ☐Money areas | ☐Treatment |
| ☐Claims and payment | ☐Precertification and preauthorization (for treatment approvals). This is when we give you an OK for a treatment. | ☐Dental |
| ☐Diagnosis (name of illness or health problem) | | ☐Vision |
| ☐Eligibility | | ☐Pharmacy |
| | | ☐Other: _____ |

I will also let Anthem share this type of sensitive (very personal) records below. Check all boxes that apply to you.

☐All sensitive records below[2]

OR

☐Just some records about topics checked below

| | | |
|---|---|---|
| ☐Abortion | ☐Testing of genes | ☐Mental health |
| ☐Abuse (sexual/physical/mental) | ☐Being pregnant | ☐Sexual diseases passed on to others |
| | ☐HIV or AIDS | ☐Other: _____ |

**PART B: People or companies who will get my records**

5. Check the box of the person or company that you will allow to see your records and write the full name of that person or company. Tell us the full name of the person or company. Please be specific. Please do not use a general term like "my daughter" or "my son."
6. If you check "Other person or company," please give:
   - The first and last name (if you have it).
   - The company name (if this applies to you). And their relationship to you.

**PART C: My records**

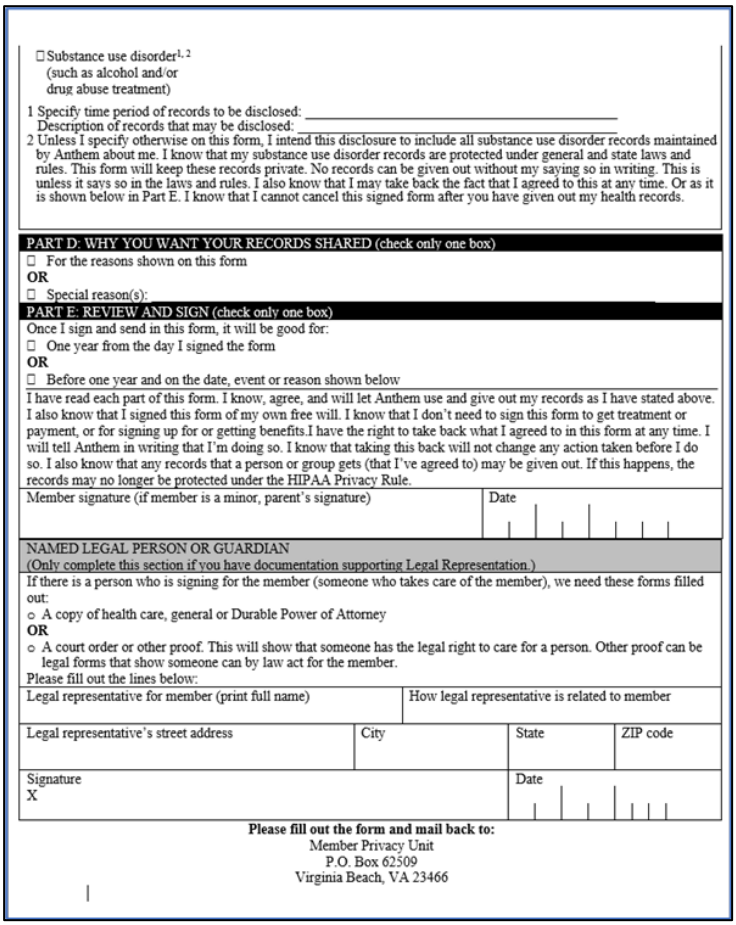
Tell us what records you will let us give out: all or just some.

7. To give out all of your records, check the first box.
8. To give out only some records, check the second box.
9. The last section is about topics potentially very personal or very private to you. If you agree that we can give out these types of records, check those boxes.

**Please read the following for help completing page two of the form.**

**PART D: Why you want your records shared**

10. The first box tells us to give out your records for the reasons as shown on this form.
11. The second box tells us a special reason. This could be talking about a life insurance claim. This might be with a lawyer or family member. Write your reason in the space.



☐ Substance use disorder[1, 2]
(such as alcohol and/or drug abuse treatment)

1 Specify time period of records to be disclosed: _____
Description of records that may be disclosed: _____

2 Unless I specify otherwise on this form, I intend this disclosure to include all substance use disorder records maintained by Anthem about me. I know that my substance use disorder records are protected under general and state laws and rules. This form will keep these records private. No records can be given out without my saying so in writing. This is unless it says so in the laws and rules. I also know that I may take back the fact that I agreed to this at any time. Or as it is shown below in Part E. I know that I cannot cancel this signed form after you have given out my health records.

PART D: WHY YOU WANT YOUR RECORDS SHARED (check only one box)

☐ For the reasons shown on this form
**OR**
☐ Special reason(s):

PART E: REVIEW AND SIGN (check only one box)

Once I sign and send in this form, it will be good for:
☐ One year from the day I signed the form
**OR**
☐ Before one year and on the date, event or reason shown below

I have read each part of this form. I know, agree, and will let Anthem use and give out my records as I have stated above. I also know that I signed this form of my own free will. I know that I don't need to sign this form to get treatment or payment, or for signing up for or getting benefits.I have the right to take back what I agreed to in this form at any time. I will tell Anthem in writing that I'm doing so. I know that taking this back will not change any action taken before I do so. I also know that any records that a person or group gets (that I've agreed to) may be given out. If this happens, the records may no longer be protected under the HIPAA Privacy Rule.

| Member signature (if member is a minor, parent's signature) | Date |
|---|---|
| | |

NAMED LEGAL PERSON OR GUARDIAN
(Only complete this section if you have documentation supporting Legal Representation.)

If there is a person who is signing for the member (someone who takes care of the member), we need these forms filled out:
○ A copy of health care, general or Durable Power of Attorney
**OR**
○ A court order or other proof. This will show that someone has the legal right to care for a person. Other proof can be legal forms that show someone can by law act for the member.
Please fill out the lines below:

| Legal representative for member (print full name) | How legal representative is related to member | | |
|---|---|---|---|
| | | | |
| **Legal representative's street address** | **City** | **State** | **ZIP code** |
| | | | |
| **Signature**<br>X | | **Date** | |
| | | | |

**Please fill out the form and mail back to:**
Member Privacy Unit
P.O. Box 62509
Virginia Beach, VA 23466

**PART E: Review and sign**

Once you sign the form, it will be good for:

12. Check the first box for one year. That's the normal time.
13. Check the second box to say the form you sign will be good for less than a year. Then give the date you want it to end.
14. **Sign your name and put the date on the form.** Your name and signature *must* match what you wrote in Part A.
15. If you are signing this form for someone: If you have forms that say you have Power of Attorney for healthcare, or are a legal guardian, or conservator, you must do this:
    - Fill in **Named Legal Person or Guardian**.
    - Give us a copy of the legal form that shows you have Power of Attorney. Put it in with this form.

Here are samples of legal forms. These are used when a person needs someone else to make choices for them.

- **Health Care, General, or Durable Power of Attorney.** This form gives someone the legal power to act for you. This person can make healthcare choices for you. It might say this on the form: "to take charge of my person in the case of sickness of any kind." It may also say this: "and in general, to do and act for me and in my name all that I might do if I am not there."
- **Legal Guardianship.** This is when the court names someone to care for a person.
- **Conservatorship.** This happens when a judge names a person to be in charge. This would be when a person can't make choices for him- or herself.
- **Executor of estate.** This type of form would be used when the person who is being spoken for has died.

Anthem

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### PART A: MEMBER

| Member last name | Member first name | Middle initial | Member date of birth |
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| Member street address | City | State | ZIP code |
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### PART B: PEOPLE OR COMPANIES WHO WILL GET MY RECORDS

The people or companies listed and checked below have the right to see my records. (They must be 18 or older.) Please check each box that applies. Write in first and last names.

| | |
|---|---|
| ☐ My spouse (first and last name) | ☐ My parents (If you are over 18, write in first and last names) |
| ☐ My adult children (first and last names) | ☐ Other (First and last name if you have it. This could be a person or the name of a company. Also, write what this person or company has to do with you.) |

### PART C: MY RECORDS

I will let Anthem share the records below. (Check only one box.):

☐ All my health records. This includes records about your health, a diagnosis (name of illness or health problem), claims, names of doctors, and other healthcare providers. Records also can be about money, like billing and banking. Checking this box won't let others see sensitive (very personal) records unless I agree to it below.

**OR**

☐ Only some records. (Check all that apply to you.)

- ☐ Appeal
- ☐ Benefits and coverage
- ☐ Bills
- ☐ Claims and payment
- ☐ Diagnosis (name of illness or health problem)
- ☐ Eligibility
- ☐ Doctor and hospital
- ☐ Doctor's records
- ☐ Money areas
- ☐ Precertification and preauthorization (for treatment approvals). This is when we give you an OK for a treatment.
- ☐ Referral (when your main doctor says it's OK to see a special doctor for certain treatment)
- ☐ Treatment
- ☐ Dental
- ☐ Vision
- ☐ Pharmacy
- ☐ Other: _____

I will also let Anthem share this type of sensitive (very personal) records below. Check all boxes that apply to you.

☐ All sensitive records below[2]

**OR**

☐ Just some records about topics checked below

- ☐ Abortion
- ☐ Abuse (sexual/physical/mental)
- ☐ Testing of genes
- ☐ Being pregnant
- ☐ HIV or AIDS
- ☐ Mental health
- ☐ Sexual diseases passed on to others
- ☐ Other: _____

☐ Substance use disorder[1, 2]
(such as alcohol and/or
drug abuse treatment)

1 Specify time period of records to be disclosed: _____
Description of records that may be disclosed: _____

2 Unless I specify otherwise on this form, I intend this disclosure to include all substance use disorder records maintained by Anthem about me. I know that my substance use disorder records are protected under general and state laws and rules. This form will keep these records private. No records can be given out without my saying so in writing. This is unless it says so in the laws and rules. I also know that I may take back the fact that I agreed to this at any time. Or as it is shown below in Part E. I know that I cannot cancel this signed form after you have given out my health records.

## PART D: WHY YOU WANT YOUR RECORDS SHARED (check only one box)

☐ For the reasons shown on this form ( health, a diagnosis (name of illness or health problem), claims or billing)

**OR**

☐ Special reason(s):

## PART E: REVIEW AND SIGN (check only one box)

Once I sign and send in this form, it will be good for:

☐ One year from the day I signed the form

**OR**

☐ Before one year and on the date shown Date

I have read each part of this form. I know, agree, and will let Anthem use and give out my records as I have stated above. I also know that I signed this form of my own free will. I know that I don't need to sign this form to get treatment or payment or for signing up for or getting benefits. I have the right to take back what I agreed to in this form at any time. I will tell Anthem in writing that I'm doing so. I know that taking this back will not change any action taken before I do so. I also know that any records that a person or group gets (that I've agreed to) may be given out. If this happens, the records may no longer be protected under the HIPAA Privacy Rule.

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(Only complete this section if you have documentation supporting Legal Representation.)

If there is a person who is signing for the member (someone who takes care of the member), we need these forms filled out:

o A copy of Health Care, General or Durable Power of Attorney

**OR**

o A court order or other proof. This will show that someone has the legal right to care for a person. Other proof can be legal forms that show someone can by law act for the member.

Please fill out the lines below:

| Legal representative for member (print full name) | How legal representative is related to member | | |
|---|---|---|---|
| Legal representative's street address | City | State | ZIP code |
| Signature<br>X | | Date | |

**Please fill out the form and mail back to:**

Member Privacy Unit
P.O. Box 62509
Virginia Beach, VA 23466