PART D: PURPOSE OF THIS APPROVAL

☐ To give out the information as shown on this form
OR
☒ For this reason(s): To assist in the Appeal process

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If this document was not already withdrawn, this approval will end on the earliest of the following dates: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 and Blue Shield 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 and Blue Shield 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 and Blue Shield. 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
X	

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 member
N/A	N/A

Legal representative street address	City	State	ZIP code
N/A	N/A		

Signature	Date
X	

Please return the completed form to:
Anthem Blue Cross and Blue Shield

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