

## INDIVIDUAL AUTHORIZATION (for release of PHI from Provider to Company)

Instructions: Please complete the following information exactly as it appears on your member identification card. Complete the form in its entirety and include as much information as possible. If necessary, call the number listed on the back of your member ID card for assistance.

Individual Last Name	Individual First Name	Middle Initial	Group ID Number
Individual ID Number (from Member ID Card)	Social Security Number (optional)	Date of Birth (mm/dd/yyyy)	Daytime Telephone (with Area Code)
		/ /	
Individual Street Address	City	State	Zip Code

**Part A:** I authorize the following person or types of people to disclose my information:

Name of Provider (i.e. physician, hospital):

Relationship to the individual \_\_\_\_\_

**Part B:** I authorize the following company and its affiliates and agents to receive my information.

Wellmark Blue Cross and Blue Shield

**Part C:** I authorize the following information to be used or disclosed on my behalf (check one block):

**All my information** including health (e.g. diagnosis, claims, provider) and financial information (e.g. premium information, checking account) may be disclosed

**OR**

**Only limited information** may be disclosed (check all applicable blocks below)

**Limited Information**

- |   |  |
|---|--|
| <input type="checkbox"/> Appeal<br><input type="checkbox"/> Benefits & coverage<br><input type="checkbox"/> Billing<br><input type="checkbox"/> Claims & Payment<br><input type="checkbox"/> Diagnosis & Procedure<br><input type="checkbox"/> Eligibility & Enrollment<br><input type="checkbox"/> Financial<br><input type="checkbox"/> Medical Records (excludes psychotherapy notes*) | <input type="checkbox"/> Physician & hospital<br><input type="checkbox"/> Pre-certification & pre-authorization<br><input type="checkbox"/> Referral<br><input type="checkbox"/> Treatment<br><input type="checkbox"/> Dental<br><input type="checkbox"/> Vision<br><input type="checkbox"/> Pharmacy<br><input type="checkbox"/> Behavioral Health<br><input type="checkbox"/> Other: _____ |
|---|--|

I authorize the release of the following types of sensitive information (check all blocks that apply):

<input type="checkbox"/> Abortion	<input type="checkbox"/> Maternity
<input type="checkbox"/> Abuse (sexual/physical/mental)	<input type="checkbox"/> Mental health
<input type="checkbox"/> Alcohol/substance abuse	<input type="checkbox"/> Sexually transmitted or other communicable diseases
<input type="checkbox"/> HIV or AIDS	<input type="checkbox"/> Other _____

**Part D:** The purpose of my authorization is (check one block):

<input type="checkbox"/> To disclose the information at my request
<input type="checkbox"/> For the following purposes: _____

**Part E:** Expiration Date. If not previously revoked, this authorization will terminate in the earliest of the following date:

- the date my coverage ends (only if disclosure requested by insurance company); or
- one year from the signature date below; or
- upon the following date, event or condition (within the one year time frame): \_\_\_\_\_

**Part F:** I have read the contents of this authorization and understand and agree to the use and disclosure of my information as specified above. I also understand this authorization is voluntary and that the person listed in Part A will not condition my treatment, payment, or enrollment or eligibility for benefits on signing this authorization.

I have the right to revoke this authorization at any time by giving written notice of my revocation to the person listed in Part A. I understand that my revocation will not affect any action taken before my written revocation notice is received. I also understand that information disclosed may be subject to re-disclosure by the recipient in which case it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this authorization.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Individual Signature**

**Designated Legal Representative/Guardian**

If this form is signed by a legal representative/guardian on behalf of the individual, please complete the following. A copy of a Health Care Power of Attorney, a court order or other documentation establishing custody or other legal documentation demonstrating the authority of the legal representative to act on the individual's behalf must be attached.

Legal representative (print full name): \_\_\_\_\_

Legal relationship to individual: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**\*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.

**Please keep a copy of this form for your records and return the completed form to:  
Wellmark Blue Cross and Blue Shield of South Dakota  
PO Box 5023  
Sioux Falls, South Dakota 57117-5023**