

Instructions: Please complete the form in its entirety and include as much information as possible.

Individual last name	First name	M.I.	Group ID no. 1850VR
College name	Social Security no. (optional)	Date of birth (MMDDYY)	Daytime phone no. (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:

Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and its affiliates and agents.

Part B: I authorize the following person or types of people to receive my information (the person receiving the information must be 18 years of age or older):

S.A.I.N. Health Group plan representatives

Athletic Personnel and/or Director of Nursing – Name: _____

Chief Business Official and/or Administrator – Name: _____

Name and relationship to the individual: _____

Part C: I authorize the following information to be used or disclosed on my behalf:

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

Limited Information:

- Benefits & coverage
- Billing

- Claims & payment
- Diagnosis & procedure
- Eligibility & enrollment

- Medical records (excludes psychotherapy notes¹)
- Physician & hospital

- Treatment
- Pharmacy
- Other: _____

I also approve the release of the following types of sensitive information by Anthem Blue Cross (check all blocks that apply to you):

All sensitive information OR Just information about topics checked below:

Abortion

Alcohol/substance abuse²

HIV or AIDS

Mental health

Abuse (sexual/physical/mental)

Genetic testing

Maternity

Sexually transmitted illness

Other: _____

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

To disclose the information at my request

For the following purposes:

Auditing, enrollment, billing, financial analysis, stop-loss/reinsurance, and benefit analysis.

Part E: Expiration date. If not previously revoked, this authorization will terminate on the earliest of the following dates:

• The date my coverage ends (only if disclosure requested by insurance company)

• One year from the signature date below

• Upon the following date, event or condition (within the one year time frame): _____ (MMDDYY)

• Accident date: _____ (MMDDYY)

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, 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.

Individual signature X	Date (MMDDYY)
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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
Individual signature X	Date (MMDDYY)

¹ 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.

² I understand that my alcohol/substance abuse records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time, or as described below in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.

Please keep a copy of this form for your records and return the completed form to:

Student Insurance

10801 National Blvd., #603

Los Angeles, CA 90064

Email to: claims@studentinsuranceusa.com

Phone: 1-310-826-5688

Fax to: 1-310-826-1601

Corporate Privacy has approved this form and it is an accepted HIPAA Authorization for the S.A.I.N. (Student Athlete Insurance Network) Group. 1/2017