S.A.I.N.
Student & Athlete Insurance Network

HIPAA Individual Authorization
Student & Athlete Insurance Network

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

Individual Last Name	Individual First Name		M.I.	Group ID Number
College Name	Social Security Number *(optional)*	Date of Birth *(mm/dd/yyyy)*	Daytime Phone Number *(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):*

Student Health SVC, Athletic Trainer, Risk Mgt, Police Officer, Security

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
- [X] Benefits & coverage
- [X] Billing
- [X] Claims & payment
- [X] Diagnosis & procedure
- [X] Eligibility & enrollment
- [X] Medical records (excludes psychotherapy notes*)
- [X] Physician & hospital
- [X] Treatment
- [X] Pharmacy
- [ ] Other: _____

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

- [ ] To disclose the information at my request
- [ ] For the following purposes: Claims Administration: Billing, Payments, Claims Status and related issues

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); or
- One year from the signature date below; or
- Upon the following date, event or condition (within the one year time frame): _____/_____/_____
- Accident date: _____/_____/_____

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.

Individual Signature X	**Date**

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 X	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:
Student Insurance
11661 San Vicente Blvd. #200
Los Angeles, CA 90049
Email to: Ken@studentinsuranceusa.com
Fax to: 310-826-1601

Anthem Blue Cross Legal has approved this form and it is an accepted HIPAA Authorization for the SAIN (Student & Athlete Insurance Network) Group. 8/08