

If you have any questions, please feel free to call us at the customer service number on your member identification card. Please read the following for help completing page one of the form.

Part A: Minor member information

This section applies to a minor member who is asking for the release of his or her information to another person.

- 1 Print your last name, first name, and middle initial.
- 2 Write your date of birth in this format: mmddyyyy. (If you were born on October 5, 2010, you would write 10052010.)
- 3 Write your full street address, city, state, and ZIP code.
- 4 Write your daytime phone number (including area code.)
- 5 Write your cell/mobile number (including area code.)
- 6 **Identification number**
You will find this number on your member identification card.
- 7 **Group number**
You will find this number on your member identification card. If your identification card does not have a group number, leave this blank.

Part B: Person who will receive this information

- 8 Write the full name of the person that you want us to give your information to. Please don't use a general term like "my mother" or "my father" as it will not be accepted. You need to be specific.
- 9 If you select "Other," give the first and last name and how they relate to you.

Part C: Information that can be released

This section tells us what information you would like us to release: all or just some.

- 10 For "all sensitive information," check the first box.
- 11 For "only specific topics," check the second box and select the topics you would like.

Part D: Purpose of this approval

This section tells us the reason you've asked for the release of your information.

- 12 Check the first box to let us know to give out this information as shown on this form.
- 13 Check the second box for a specific reason.

California Minor Authorization Form

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

This form is to be filled out by a minor member if there is a request to release the member's health information to another person as designated under the California Confidential Communications of Medical Information Assembly Bill 1184.

Part A: Member information

Member last name 1	Member first name	Middle initial	Member date of birth (MMDDYYYY) 2
Member street address 3	City	State	ZIP code
Daytime telephone number (with area code) 4	Cell/mobile telephone number (with area code) 5	Identification number (see identification card) 6	Group number (see identification card) 7

Part B: Person or people who will receive this information

The following person or people have permission to my information. Please enter the first and last name(s) of the person or people in the fields below. (They must be 18 years old or older).

My parent(s) or legal guardian(s): 8

9 Other relationship: Enter first and last name, and how they are related to you.
Other relationship: Name(s):

Part C: Information that can be released

10 I approve the release of the following types of sensitive information by Anthem (check all boxes that apply to you):

All sensitive information¹
OR

11 Just sensitive information about topics checked below

<input type="checkbox"/> Abuse (sexual/physical/mental)	<input type="checkbox"/> Mental health	<input type="checkbox"/> Sexually transmitted illness
<input type="checkbox"/> Genetic testing	<input type="checkbox"/> Reproductive health ² (including abortion, maternity, etc.)	<input type="checkbox"/> Substance use disorder ²
<input type="checkbox"/> HIV or AIDS		

1 Unless I specify otherwise on this form, I intend this disclosure to include all substance use disorder records maintained by Anthem about me. I understand that my substance use disorder 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 in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.

2 Reproductive health includes, but is not limited to, both male and female infertility, maternity, pregnancy loss, miscarriage, family planning, birth control, both elective and spontaneous abortion, and any other related care or services.

Part D: Purpose of this approval – Check only one box.

12 To give out the information as shown on this form.
OR

13 For this reason(s):

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

Part E: Date your approval expires

You have two choices of when you would like this approval to end.

- 1 Check the first box if you would like the standard option. This will be in effect for three years from the date on this form, or when you turn 18, whichever comes first.
- 2 Check the second box for an earlier date and give the date you wish this approval to end.

Part F: Review and approval

- 3 Sign your name and put the date on the form. Your name and signature must match the information in Part A.

Part E: Date your approval expires – Check only one box.

1 If this document was not already withdrawn, this approval will end on the earliest of the following dates:

Check this box if you would like the standard expiration which is three years from the signature date in Part F or whenever you turn 18, whichever comes first.

OR

2 Check this box if you would like to choose a date that is less than three years or before you turn 18:
____/____/____ (MMDDYYYY)

Part F: Review and approval

I have read the contents of this form. I understand, agree, and allow Anthem to the use and release of my information as I have stated above or as required by applicable law. I also understand that signing this form is of my own free will. I understand that Anthem 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. 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.

Minor member signature 3 Date (MMDDYYYY)

X _____

Please return the completed form to:
Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

Be sure to keep a copy of this form for your records.

For internal use only: Inquiry tracking number

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California Minor Authorization Form



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Part A: Member information

Member last name		Member first name		Middle initial	Member date of birth (MMDDYYYY)
Member street address		City		State	ZIP code
Daytime telephone number (with area code)	Cell/mobile telephone number (with area code)	Identification number (see identification card)		Group number (see identification card)	

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Other relationship: _____ Name(s): _____

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Date (MMDDYYYY)

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