AUTHORIZATION TO RELEASE MEDICAL INFORMATION FORM

Purpose:

This authorization to release medical information is for the purpose of
____.

Member whose Medical Information is to be Released:

Member Name: ________________________________
Policy or Contract Number: ________________________________
Group Number: ________________________________
Date of Birth: ________________________________

Authorization for Florida Blue to Release Medical Information:

I authorize Florida Blue to release the following medical information concerning Member to the persons listed above:

- ☐ Identifying information (e.g., name, address, age, gender);
- ☐ Health care coverage information; and
- ☐ Past, present and future claims information, including HIV test results; alcohol or drug abuse diagnosis and treatment information[1]; psychological/psychiatric testing and evaluation information; and any other information regarding medical diagnosis, treatments, or conditions (except for any period of time during which a PHI address[2] was in effect).

Florida Blue may Release Member's Medical Information to:

_____ ____________ _______________ ____________ _____ _____ _____

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

____.

Effect of Granting this Authorization:

By law, this authorization must indicate that persons other than Florida Blue receiving Member's medical information may not have to obey federal health information privacy laws and Member's

medical information may be further released by those persons. **Florida Blue must obey those laws and may only release Member's medical information as those laws provide.**

This authorization is voluntary and is not a condition of enrollment in a health plan, eligibility for benefits or payment of claims.

Expiration:

This authorization will expire (*complete one*)

□______//______//______ month/day/year
OR

□ the date Member's Florida Blue health coverage ends.

As it relates to Member's alcohol or drug abuse diagnosis and treatment information, this authorization will be effective only long enough to carry out the purpose for which it was given.

Copy of Authorization:

Please keep a copy of your signed authorization. A photocopy is as valid as the original.

Right to Withdraw Authorization:

I understand that I may withdraw this authorization at any time by giving written notice to the office listed below except I may withdraw this authorization as it relates to Member's alcohol or drug abuse diagnosis and treatment information by giving oral or written notice to that office. I further understand that withdrawal of this authorization will not affect any action taken by Florida Blue in reliance on this authorization prior to receiving my notice of withdrawal.

Contact Office: ((((Insert as appropriate))))))

Signature:

Member Signature:______________________________Date: ________________

If a legal representative signs this authorization form on behalf of Member, please complete the following:

[3]Legal representative's name: ____

Relationship to Member: ____

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[1] Florida Blue will only release Member's alcohol or drug abuse diagnosis and treatment information necessary to carry out the purpose for which the information is to be released.

[2]A PHI address is one specified by an adult (age 18 and older) that is different than the address where the subscriber receives his or her mail.

[3] Please provide written documentation to support your status as a guardian or other legal representative.