Capital Health Plan
An Independent Licensee of the Blue Cross and Blue Shield Association

2140 Centerville Place ·Tallahassee, Florida 32308 · P.O. Box 15349 Tallahassee, Florida 32317-5349

Authorization to Use or Disclose Protected Health Information

Patient Name	Date of Birth	Verification of Identity (Driver's License, ID Card, Passport, etc.)	
Address		Member Number	Phone Number

****Complete the following only if the person authorizing the use of disclosure is not the patient:**

Name	Relationship to Patient	Legal Authority
Verification of Identity	Verification of Authority	Witness

By signing this form, I ____authorize ___________________
to release the following protected health information: ____
____

TO:
Name ______________________________________ Attn: ___________________________________
Address ____________________________________ Phone _______________________
____
____
____

I further authorize the disclosure of information related to: (Check all that are approved.)

☐ Mental Health Conditions or Treatments ☐Substance Abuse ☐HIV/AIDS
☐ Other Sexually Transmissible Diseases ☐Genetic Disorders

I further authorize the disclosure of: (Check all that are approved.)
☐Records created by other health care providers, not associated with the organization or entity above, which may be included in the health information described.
☐Records of the same type listed above for disclosure, created after today's date, until the expiration date shown below, or six (6) months from the date of this authorization, whichever comes first.

The purpose of the use or disclosure is: ____
I understand that once information is disclosed, the information is subject to redisclosure and may no longer be protected by federal privacy regulations. I hereby release (the facility) and its employees from any and all liability that may arise from the release of information as I have directed.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records supervisor. I understand the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my health plan when the law provides my plan with the right to contest a claim under my policy. Unless otherwise revoked this authorization will expire in **six (6)** months from the date signed below.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to assure treatment. I understand I may inspect or copy the information used or disclosed as provided in **CFR 164.524**. If I have questions about disclosure of my health information I can contact a Medical Records Supervisor, Member Services or the Privacy Officer.

Signature of Patient or Legal Representative:
____ Date: ____________