

How to Complete a Communication Directive

Attached you will find a copy of Capital Health Plan's Communication Directive form. This form enables you to designate an individual or individuals with whom CHP may discuss your medical care and will allow release of your protected health information to a family member, relative, close friend or other person identified by you.

INSTRUCTIONS:

- Enter your name on the top line
- Enter the names of those you wish to designate on the accompanying lines
- Initial and date the statement noting that you are aware that this would include any and all of your health care information including mental health, alcohol or drug abuse and HIV testing or diagnosis

The next paragraph further explains that this form allows discussion of your health care only. It does not allow anyone to receive copies of your medical records. You may cancel this directive at any time. You may add any instructions or restrictions to this communication approval.

Parents do not need to complete Communication Directives for their children under 18 years of age to be able to discuss your child's care with the physician, unless you wish to have someone else designated to discuss your child's care. If an emancipated minor is treated for superconfidential reasons, the child will need to complete a Communication Directive form if they wish this information to be discussed with a parent.

PLEASE:

- Date and sign the form
- Include your date of birth
- Print your name
- Note your CHP number
- Add the last four (4) digits of your social security number
- Return signed form to : Capital Health Plan- Medical Records

P.O. Box 15349

Tallahassee, Fl. 32317 -5349

IMPORTANT REMINDER

The final section relates to revocation (cancellation of the above designations). This is to be signed in the future only if you decide that the person/persons noted above may no longer be able to discuss your health care with CHP personnel.

Please direct any questions you may have to Capital Health Plan Member Services at 383-3311, or for hearing impaired (TDD) (850) 383-3534, Monday through Friday 8am through 5 p.m.

COMMUNICATION DIRECTIVE FORM

I, _____, authorize Capital Health Plan to release (or disclose) verbal information from my medical records or billing records relating to my identity, diagnosis, prognosis, or treatment to:

Spouse Name: _____
Child Name: _____
Sibling Name: _____
Other Name: _____
Other Name: _____

I understand that the extent or nature of the medical information to be released includes any and all medical records, including MENTAL HEALTH, ALCOHOL, AND/OR DRUG ABUSE TREATMENT AND HIV (AIDS) TESTING, TREATMENT OR DIAGNOSIS.

Initial/Date _____

I also understand that the purpose or need for this release is to assist in communication of my medical care. Furthermore, I understand that this release may be cancelled. It will remain in force until such time as it is cancelled by myself. I understand this is for verbal information and does not authorize release of medical records which would require a separate written authorization.

PROHIBITION OF DISCLOSURE: The protected health information to be released is confidential. This directive does not authorize Capital Health Plan to release this information to any other party.

SPECIAL INSTRUCTIONS OR RESTRICTIONS REQUESTED BY PATIENT:

DATE _____

PATIENT SIGNATURE _____ DATE OF BIRTH _____

PRINTED NAME OF PATIENT _____ CHP# _____

LAST FOUR (4) DIGITS OF SOCIAL SECURITY NUMBER _____

OR

CANCELLATION SECTION:

I hereby revoke the designation of this individual to receive protected health information.

Patient Signature

Date