Florida Blue

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

****PLEASE READ THE ENTIRE FORM BEFORE SIGNING BELOW****

Member (Name of person whose health information is being disclosed):

Name: _____ Date of Birth: ____/____/____
First Middle Last MM DD YYYY

Address: _____
Street Address City State Zip Code

Policy or Contract Number: _____ Group Number: _____

PURPOSE: To permit the office of the Records Custodian of Blue Cross and Blue Shield of Florida, Inc. d/b/a Florida Blue and/or Health Options, Inc. (collectively, "Florida Blue") to respond to a request for the release of Protected Health Information.

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

Laws and regulations require that some sources of information have a signed authorization or permission form before releasing it. Also, some laws require specific authorization for the release of information about certain conditions and from educational sources.

By signing this form, I voluntarily authorize, give my permission and allow use and disclosure:

OF WHAT: ALL OF MY HEALTH INFORMATION, including:

(1) All records and other information regarding my health care coverage, including, but not limited to, past, present and future claims and coordination of benefits.

(2) All records and other information regarding my health history, treatment, hospitalization, tests, and outpatient care. *This information may relate to sensitive health conditions (if any), including but not limited to*:
   a. Drug, alcohol, or substance abuse
   b. Psychological, psychiatric or other mental impairment(s) or developmental disabilities (excludes "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501)
   c. Sickle cell anemia
   d. Birth control and family planning
   e. Records which may indicate the presence of a communicable disease or non-communicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis
   f. Genetic (inherited) diseases or tests

(3) Copies of educational tests or evaluations, including Individualized Educational Programs, assessments, psychological and speech evaluations, immunizations, recorded health information (such as height, weight), and information about injuries or treatment.

(4) Information created before or after the date of this form.

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FROM WHOM: **ALL information sources**, including, but not limited to, medical and clinical sources (hospitals, clinics, labs, pharmacies, physicians, psychologists, etc.), including mental health, correctional, addiction treatment, Veterans Affairs health care facilities, state registries and other state programs, all educational sources that may have some of my health information (schools, records administrators, counselors, etc.), social workers, rehabilitation counselors, insurance companies, health plans, health maintenance organizations, employers, pharmacy benefit managers, worker's compensation programs, state Medicaid, Medicare and any other government program.

TO WHOM: Specific person(s) or organization(s) permitted to receive my health information:

Name: RECORDS DEPOSITION SERVICE, INC. Relationship to Member: _____

Address: PO BOX 5054 (Street Address) SOUTHFIELD (City) MI (State) 48086-5054 (Zip Code)

Telephone: 248-357-3330 Facsimile: _____ E-mail: INFO@RECDEP.COM

Please list any additional persons or organizations permitted to receive your health information on a separate sheet. Disclosure of health information may be through electronic interchange.

EFFECTIVE PERIOD: This authorization will expire one (1) year from the date signed below unless an alternative expiration date or event is specified as follows: _____.

RIGHT TO REVOKE: You have the right to revoke this authorization and withdraw your permission at any time regarding any future uses by giving written notice to: Blue Cross and Blue Shield of Florida, Inc., Records Custodian, 4800 Deerwood Campus Pkwy, DCC1-7, Jacksonville, Florida 32246. Revocation will not apply to any actions already taken as a result of this authorization.

IN ADDITION:

I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.

I understand that once my health information is disclosed, it may be subject to lawful redisclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.

I hereby release Florida Blue from any legal responsibility or liability for the disclosure of the above information to the extent authorized herein.

I have read all pages of this form and agree to the disclosures above from the types of sources listed.

SIGNATURE:

_____ _____

Signature of Member or Member's Legal Representative — Date

*Legal Representative (if applicable): _____

Print Name

Relationship to Member: _____

**Please provide written documentation to support your status as Legal Representative.*

NOTE: This form is invalid if modified. You are entitled to receive a copy of this form after you sign it.