Florida Blue

# Protected Health Information Authorization for Customer Service Inquiries

## PURPOSE

I am the member listed in Section I.

This authorization is at my request to permit Blue Cross and Blue Shield of Florida, Inc., HealthOptions, Inc., and Florida Blue Medicare, Inc. (together, "Florida Blue") to respond to customer service inquiries regarding my Protected Health Information regarding health, dental and long-term care products.

*Please complete this entire form and return to:*

Florida Blue Access
Authorization Unit
P.O. Box 45296
Jacksonville, FL 32232

## SECTION I

Please provide the following information regarding the person whose Protected Health Information is to be released.

Member Name: _____

Member Number: _____

Group Number: _____ Date of Birth: _____

## SECTION II

I authorize Florida Blue to release, orally and/or in writing, the following Protected Health Information concerning me:

- Identifying information (e.g., name, address, age, gender);
- Health care coverage information (i.e., general & plan-specific benefit information);
- Past, present and future claims information (except for any period of time during which a Confidential Communication address[1] was in effect); and
- Coordination of Benefit Information.

## SECTION III

Please identify the person(s) to whom the member's Protected Health Information may be released and their relationship, i.e., sales agent, employer health benefit representative, parent, family member, friend, corporation, organization, law firm, vendor.

My information may be given to the person(s) listed below.

Please Print:

Name: _____ Relationship to Member: _____

Name: _____ Relationship to Member: _____

Name: _____ Relationship to Member: _____

## SECTION IV

By law, this authorization must indicate that persons other than Florida Blue receiving member's Protected Health Information may not have to obey federal health information privacy laws and member's Protected Health Information may be further released by those persons.

I further understand that if I have identified a sales agent or an employer health benefit representative in Section III to whom my Protected Health Information may be released, Florida Blue will have no further liability as to the further release of my Protected Health Information by those designated persons.

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

**SECTION V**

This authorization will expire:

_____ / _____ / _____
Month Day Year

**OR**

_____
The date member's Florida Blue health coverage ends

It is advised that you place a specific expiration date on this authorization if you are designating a sales agent or employer as an authorized representative, or any other person for whom you may have designated to assist you with a specific, short-term task.

**SECTION VI**

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

**SECTION VII**

**Right to Withdraw Authorization**
I understand that I may withdraw this authorization at any time by giving written notice to the address listed on page 1 of this form. 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 written notice of withdrawal.

**SECTION VIII**

**Signature**

Member Signature:

_____

Date: _____

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

Legal Representative's Name[2]:

_____

Date Signed: _____

Relationship to the member:

_____

*[1]A Confidential Communication address is one specified by an adult (age 18 or older) that is different than the address where the subscriber receives his or her mail.*

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



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