# AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Florida Health Care Plans®
An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. BOX 9910
DAYTONA BEACH, FL 32120

Medical Records FAX:
386-481-5009 OR
888-427-4544

## I. PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____
Address: _____ Social Security # (last 4): _____
_____ Home Telephone #: _____
FHCP MRN #: _____ Cellular Telephone #: _____
Email Address: _____ Work Telephone #: _____

## II. PROVIDER/FACILITY AUTHORIZED TO RELEASE PHI

Name: _____
Address: _____
Phone # _____ Fax #: _____

## III. PERSON/FACILITY AUTHORIZED TO OBTAIN PHI

Name: _____ Relationship to Patient: _____
Address: _____
Phone #: _____ Fax #: _____
Email Address: _____

## IV. PHI REQUEST AND DELIVERY INFORMATION

**Date(s) of Service or Date Range for Release:** _____

**Record Type(s):** ☐Office Visits ☐Immunizations ☐Operative ☐Radiology Report
☐Labs-Date Drawn (specify): ☐Other (specify):

**Purpose:** ☐Continuing Care ☐Legal ☐Insurance ☐Patient ☐Other (specify):

**Requested Format:** ☐Paper ☐Electronic (CD or Email – Please Circle) ☐Verbal

**Delivery Method:** ☐Mail ☐Email (if possible) ☐Pick up ☐Fax (Medical Facilities Only)

## V. APPROVAL OF RELEASE OF SENSITIVE PHI

Check and initial to approve disclosure of any PHI that may contain information pertaining to:
☐HIV/AIDS: ☐Drug /Alcohol: ☐Psychiatric: ☐Genetic Counseling/Testing:

I understand that this authorization extends to all or any part of my records, which may include psychiatric, alcohol/drug, genetic counseling/testing, and/or AIDS (Acquired Immunodeficiency Syndrome) information, any may include the result of an HIV test or the fact an HIV test was performed. I expressly consent to the release of information as designated above. **I understand that I have the right to revoke this authorization at any time and that if I revoke this authorization that I must do so in writing and present my written revocation to FHCP Medical Records Department. I understand that the revocation will not apply to PHI that has already been released as requested by this authorization. I understand that any disclosure of PHI carries with it the potential for redisclosure where confidentiality laws or regulations may not apply. It also prohibits FHCP from making any further disclosure without the specific written authorization of the person to whom it pertains. I understand that FHCP will not condition treatment, payment, enrollment, or eligibility for benefits on whether or not I sign this authorization.**

## VI. RELEASE OF PHI EXPIRATION DATE (MUST EITHER CIRCLE OR ENTER)

☐Upon Death **OR** ☐Expiration Date: / / **OR** ☐One year from signature date.

_____ _____
**Signature of Patient or Legal Representative/Authorized Health Surrogate*** **Date**

_____ _____
**Witness** **Date**

*Legal Representative/Authorized Health Care Surrogate is defined as a court appointed guardian or personal representative, a person with a Health Care Power of Attorney specific to medical records access, a person designated as a Health Care Surrogate, or next of kin. Supporting documentation required.

**Completed form can be returned by mail to the address at the top of this page, by fax to the number(s) at the top of this page, or scanned and sent by email to** medrecroi@fhcp.com.