BlueCross BlueShield of Florida Health Options®

Health Options and its Parent, Blue Cross and Blue Shield of Florida, are Independent Licensees of the Blue Cross and Blue Shield Association.

Please complete this entire form and return to:
Blue Cross and Blue Shield of Florida, Inc.
Access Authorization Unit
Post Office Box 025314
Miami, Florida 33102-5314

AUTHORIZATION TO RELEASE "PROTECTED HEALTH INFORMATION" – ACCESS

PURPOSE

This authorization is at my request to permit Blue Cross and Blue Shield of Florida, Inc., Health Options, Inc. and Florida Combined Life Insurance Company, Inc. (together, BCBSF) to respond to customer service inquiries regarding my Protected Health Information.

SECTION I

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

Member Name: _____

Policy or Contract Number: _____

Group Number: _____Date of Birth: _____

SECTION II

I authorize BCBSF to release the following Protected Health Information concerning the member listed in Section I:

- Identifying information (e.g., name, address, age, gender);
- Health care coverage information; and
- Past, present and future claims information (except for any period of time during which a PHI address[1] was in effect).

SECTION III

Please identify the person(s) with whom the member's Protected Health Information may be released to and their relationship.

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 BCBSF 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.

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 BCBSF health coverage ends

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 office listed on page 1. I further understand that withdrawal of this authorization will not affect any action taken by BCBSF 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*: _____

Date Signed: _____

Relationship to the member: _____

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

_____

[1] A Protected Health Information 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.