



**AUTHORIZATION TO USE and ACCESS “PROTECTED HEALTH INFORMATION”**

**PURPOSE**

I am the member listed in Section 1. This authorization is at my request to permit Blue Cross and Blue Shield of Florida, Inc., and Health Options, Inc. (together, “Florida Blue”) to respond to customer service inquiries regarding my Protected Health Information regarding health, dental and long-term care products.

**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: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

**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<sub>1</sub> 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 release and their relationship (i.e., sales agent, employer health benefit representative, parent, family member, friend, etc.)

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

**Please Print:**

|                              |   |
|------------------------------|---|
| Name: <u>Angela Hooper</u>   | Relationship to Member: <u>*Servicing Agent</u> |
| Name: <u>Thomas Buss</u>     | Relationship to Member: <u>*Servicing Agent</u> |
| Name: <u>Spencer Barrett</u> | Relationship to Member: <u>*Servicing Agent</u> |
| Name: _____                  | Relationship to Member: _____                   |
| Name: _____                  | Relationship to Member: _____                   |

\*Barrett, Liner & Buss, LLC

**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 the 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. 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\*: \_\_\_\_\_

Date Signed: \_\_\_\_\_

Relationship to the member: \_\_\_\_\_

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

\_\_\_\_\_   
1A Confidential Communication address is on specified by an adult (age 18 or older) that is different than the address where the subscriber receives his or her mail.

\_\_\_\_\_   
Health insurance is offered by Blue Cross and Blue Shield of Florida, D/B/A Florida Blue. HMO coverage is offered by Health Options, Inc., D/B/A Florida Blue HMO, an HMO subsidiary of Florida Blue. These companies are independent licensees of the Blue Cross and Blue Shield Association.