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.

Blue Cross and Blue Shield of Florida
Post Office Box 1798
Jacksonville, Florida 32231

AUTHORIZATION TO SHARE "PROTECTED HEALTH INFORMATION"

PURPOSE
To permit Blue Cross and Blue Shield of Florida (BCBSF), Health Options Inc. (HOI) and Florida Combined Life (FCL) to respond to customer service inquiries regarding Protected Health Information.

SECTION I
Please provide the following information regarding the person whose Protected Health Information is to be disclosed.

Name: _____

Address: _____

_____

Telephone: Daytime_____ Evening _____

Date of Birth: _____ Policy or Contract Number: _____

SECTION II
Please identify the person(s) with whom your information may be shared and their relationship to you.

My information may be shared with: (Please Print.)

Name: _____ Relationship to Member: _____ ____

Name: _____ Relationship to Member: _____

Name: _____ Relationship to Member: _____

SECTION III
Please enter a date OR select an event upon which you want this authorization to expire.

This authorization will expire: _____//_____//_____
Month Day Year

OR:

_____ When my BCBSF (or subsidiary) health coverage ends

AUTHORIZATION

I hereby authorize Blue Cross and Blue Shield of Florida, Inc. (BCBSF) and/or its subsidiaries to share the following Protected Health Information concerning me:

- 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 Protected Health Information (PHI) address[1] was in effect).

I understand that my Protected Health Information may be shared with the people listed on page 1 of this form and that they may not be required to comply with federal health information privacy laws and may use, and further disclose, any of my Protected Health Information they receive.

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

SIGNATURE

Member Signature: _____ Date: _____

If someone else is signing this authorization form on behalf of the member, please provide the following information:

***Legal Representative: _____

Date signed: _____

Relationship to the member: _____

COPY OF AUTHORIZATION

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

RIGHT TO REVOKE

I understand that I may cancel my authorization at any time by giving written notice to the office listed on page 1. I further understand that cancellation of my authorization will not effect any action taken by BCBSF or its subsidiaries prior to receiving my written notice of cancellation.

**Note: ***Please provide written documentation to support your status as a legal representative and/or guardian

[1] A Protected Health Information address is one specified by an adult (over 18) that is different than the address where the subscriber receives his or her mail.