Florida Blue
P.O. Box 45296
Jacksonville, FL 32232

AUTHORIZATION FOR DISCLOSURE OF PHI RECORDS

You, as a member, or acting as a personal representative of a member, of Blue Cross and Blue Shield of Florida, Inc., Health Options, Inc., or Florida Blue Medicare, Inc. ("Florida Blue") or Truli for Health, can authorize the disclosure of your protected health information in certain records ("**PHI Records**") with the people or companies listed below. Please complete all sections of this form and then return the signed form to the address listed above.

1. Member Information (Individual whose PHI Records will be disclosed):

Member contract number	Date of birth	
Member first name	Middle initial	
Member last name		
Address		
City	State	Zip code
Telephone number		

2. I authorize the disclosure of my PHI Records to the following people or companies:

Person or company name		
Address		
City	State	Zip code
Telephone number		

3. I authorize the disclosure of my PHI Records for the following purpose:

Please check **ONLY ONE** box:

☐ At my request – no specific purpose ☐ Specific purpose: _____

_____

Example: Help me administer my health insurance benefits

4. I authorize the disclosure of the following PHI records:

Please check **ONLY ONE** box:

☐ A claim summary report listing the provision of, and payment for, my health care benefits or services.

☐ Specific information as described on the line below:

_____

Example: The claim related to my service on (date).

5. My authorization to disclose PHI Records will expire:

Please check **ONLY ONE** box:

☐ When I revoke this authorization in accordance with the instructions listed below

OR

☐ Upon the following date, event or condition:

_____

6. By signing below, I understand and agree:

- My PHI Records may contain information created by other persons or entities, including health care providers, and may include sensitive diagnosis and treatment information covering chronic diseases, behavioral/mental health conditions, substance use disorders, HIV/AIDS and other infectious diseases.
- If I share my PHI Records with persons outside of Florida Blue or Truli for Health, they may not be subject to state or federal privacy laws restricting its use or disclosure.
- I can get a copy of this authorization form that I have signed by sending Florida Blue a signed written request using the address at the top of this form.
- I may revoke this authorization at any time by notifying Florida Blue in writing using the address at the top of this form, however, the revocation will not have any effect on any actions taken prior to the date that my revocation is received and processed.
- This authorization is voluntary; my enrollment or eligibility for benefits with Florida Blue or Truli for Health won't change if I do not sign this form.

Sign Here

Date MM/DD/YYYY

☐ Check here and complete the Personal Representative Information section below if you are signing this form as a personal representative of the Florida Blue or Truli for Health member.

Personal Representative Information: If the member can't sign this form, a personal representative may sign, complete and return this form for the member. A personal representative is someone who has the legal right to sign this form on behalf of the member. **Please attach proof that you are the member's personal representative (for example, Power of Attorney). We can't accept this form without this documentation.**

First name	Last name	
Address		
City	State	Zip code
Telephone number		

If you have any questions regarding this form, please call Customer Service at the toll-free number on the back of your member identification card.