Please complete this entire form and return to:

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

Protected Health Information Authorization for Customer Service Inquiries

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 our customer service to disclose your Protected Health Information in connection with inquiries regarding the administration of your health, dental and/or long-term care products.

SECTION I

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

Member Name: _____

Member Number: _____

Group Number: _____ Date of Birth: _____

SECTION II

I authorize Florida Blue or Truli for Health 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[1] 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 released and their relationship, i.e., sales agent, employer health benefit representative, parent, family member, friend, corporation, organization, law firm, vendor.

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

Please Print:

Name: _____ Relationship to Member: _____

Name: _____ Relationship to Member: _____

Name: _____ Relationship to Member: _____

SECTION IV

If I share my protected health information with persons outside of Florida Blue or Truli for Health, they may not be subject to state or federal laws restricting its use or disclosure.

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 or Truli for Health 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 member's Florida Blue or Truli for Health 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 to the address listed on page 1 of this form. I further understand that withdrawal of this authorization will not affect any action taken by Florida Blue or Truli for Health 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[2]:
_____

Date Signed: _____

Relationship to the member:

_____

[1]A Confidential Communication 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.

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