Health First Health Plans

Authorization to Disclose Protected Health Information (PHI)

According to state and federal law Health First Health Plans must have your written permission to use or give out your Protected Health Information (PHI) for any purpose that is not described in our Notice of Privacy Practice.* If you want your PHI shared with someone other than you, you need to let Health First Health Plans know by completing this form.

This form authorizes Health First Health Plans to disclose your Protected Health Information (PHI) to the person indicated below.

INSTRUCTIONS: Complete all pages of this form. Please print all responses. This form must be filled out completely in order to be valid. Once completed please deliver, mail or fax the form to:

Health First Health Plans
6450 US Highway 1
Rockledge, FL 32955
Attn: Enrollment Department

Fax: 855.328.0055

A. MEMBER INFORMATION

Member Name: _____
Last First Middle

Member ID Number: _____ Date of Birth: _____

B. AUTHORIZED INDIVIDUAL(S) SECTION

Name of person to whom you are authorizing Health First Health Plans to disclose your PHI.

1) Name: _____
Last First Middle

Address: _____

Telephone: _____

2) Name: _____
Last First Middle

Address: _____

Telephone: _____

C. PURPOSE OF THE DISCLOSURE

By signing this form, I authorize Health First Health Plans to disclose my PHI to the authorized individuals listed above for the following purposes (check all that apply):

- ❑ Accessing my enrollment information (such as name, address, employer, effective date, etc.)
- ❑ Accessing my financial information
- ❑ Accessing my claims and authorizations (which may include diagnosis, procedures performed, providers seen, and case management records)
- ❑ All of the above

D. TERM

This Authorization will remain in effect indefinitely, or until the date indicated below:

- ❑ _____ (specify date)

Uses and disclosures of protected health information not covered by the Notice of Privacy Practices* or other applicable laws will be made only with your written permission. If you provide us permission to use and disclose your protected health information, you may revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose your protected health information for the reasons covered by your written permission. We are unable to take back any disclosures we have already made with your permission, and must retain our records of services provided to you. If we disclose information to your authorized individual, we cannot guarantee that your authorized individual will not further disclose the protected health information to a third party, and that state and federal laws may no longer protect such information. Completion of this form does not affect the continuation or quality of treatment by Health First, enrollment in the health plan or eligibility for benefits.

I have read and understand the terms of this Authorization. I hereby, knowingly and voluntarily, authorize Health First Health Plans to use or disclose my health information in the manner described above.

_____ _____/_____/_____

Signature of Member Date

If signed by a Legal Representative on behalf of the member, please complete the following:

a) Print your full name: _____

b) Describe your legal authority to act for the member (e.g., durable power of attorney, court order, parent of minor child, etc.)

_____

c) Attach the legal document naming you as the legal representative when you return this form.

_____ _____/_____/_____

Signature of Legal Representative Date

*The Notice of Privacy Practices can be found on the Health First Health Plans website at myHFHP.org or you can call Customer Service toll-free at 1.800.716.7737 (TTY/TDD relay:1.800.955.8771) weekdays from 8 a.m. to 8 p.m. and Saturdays from 8 a.m. to noon. From October 1 to February 14, we're available seven days a week from 8 a.m. to 8 p.m.

Health First Health Plans is an HMO plan with a Medicare contract. Enrollment in Health First Health Plans depends on contract renewal.