Authorization for the Use and Disclosure of Protected Health Information and Managed Care Plan Selection

Information Identifying the Individual Whose Records Are Being Requested

Name of Individual: _____ SSN: _____

Disclosure of your Social Security Number is not mandatory. The Agency for Health Care Administration (AHCA or Agency) may request your Social Security Number pursuant to Section 119.071, Florida Statutes. If provided, the Agency will use your information for purposes of finding the requested information.

Individual's Street Address: _____

City: _____ State: _____ Zip Code: _____

Medicaid ID or Gold Card Number: _____

Phone Number: _____ Date of Birth: _____

Provide the *specific* dates of service included. From: _____ To: _____
(Must include a specific date range mm/dd/yyyy. Or state From: Any To: All for continued access.)

Purpose for this disclosure: _____
(Cannot be blank)

Date I wish this authorization to expire (expires in one year if no date is provided): _____
(Must include a specific date mm/dd/yyyy; OR, A date far in the future for continued access)

Representative Name: (Print Name)_____

☐ **I authorize the above person(s), group or entity to select or change my managed care plan with the Agency. I understand some of my protected health information could be discussed in this selection process.**

☐ **I authorize the above person(s), group or entity to <u>verbally</u> discuss specific topics with AHCA:**

The *specific* topics to be discussed are: _____
(Cannot be blank if box is checked and must be list specific topics)

I understand the following: I have the right to revoke this authorization at any time by contacting the Agency's Privacy Officer at HIPAA Compliance Office, 2727 Mahan Drive, Mail Stop #4, Tallahassee, Florida 32308, Email: HIPAAComplianceOffice@AHCA.MyFlorida.com, Phone: 850-412-3960. I understand that any information previously disclosed would not be subject to my revocation request. The information described above may be re-disclosed by the person or group that I am giving the Agency permission to disclose to and therefore my information may no longer be protected by Federal privacy regulations. I may inspect or request copies of any information disclosed by this authorization if the Agency initiated this request for disclosure. I may refuse to sign this authorization and my refusal to sign will not affect my ability to obtain treatment, payment for health care services or eligibility for benefits.
This form specifically includes authorization to provide documents related to sensitive health conditions including: drug, alcohol or substance abuse, psychological or psychiatric treatment, sickle cell anemia, birth control or family planning, genetic diseases or tests, tuberculosis, and HIV/AIDS or STDs. **To restrict sensitive information, see Page 2.**

I DECLARE UNDER PENALTY OF LAW THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.

Printed Name (person signing the form): _____ Date: _____

Signature (Individual): _____ OR
(If the individual is signing with an X, two witness signatures are required. The representative listed above cannot be one of the witnesses.)

Signature of Legal Representative (If other than the Individual): _____

If you are a legal representative of the individual whose information you are requesting disclosure of, you must provide documentation proving your legal authority to request this information (for example, power of attorney, guardianship papers *with certified annual plan*, health care surrogate form, Custody Order, Order Appointing Personal Representative, Letters of Administration).

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Instructions for Completing this Form

1. Complete the first page of this form and return it to: **Agency for Health Care Administration, P.O. Box 5197 Tallahassee, FL 32314 , Fax :850-402-4678, Email: flenrollmentrequest@automated-health.com.**

2. Special types of health information have specific laws and rules that must be followed before that information may be disclosed:

HIV/AIDS and Sexually Transmitted Diseases (STD): All information about HIV/AIDS and sexually transmitted diseases is protected under Federal and State laws and cannot be disclosed without your written authorization unless otherwise provided in the regulations. To release HIV/AIDS or STD information, this authorization must include a statement of the specific HIV/AIDS or STD information you are giving the Agency permission to disclose. Re-disclosure of HIV/AIDS information is not allowed except in compliance with law or with your written permission. **To NOT INCLUDE this information, initial here** _____

Alcohol or Drug Treatment: Alcohol and/or drug treatment records are protected under Federal and State laws and regulations and cannot be disclosed without your written authorization, unless otherwise provided for in Federal and State laws or regulations. To release alcohol and/or drug treatment information, this authorization must include a statement of the specific information that you are giving the Agency permission to disclose (for example, "For the purposes of my assessment, treatment plan, attendance, or discharge plan.") Re-disclosure of your alcohol and/or drug treatment records is not allowed except in compliance with law or with your written permission (see 45 CFRPart 2). **To NOT INCLUDE this information, initial here** _____

Mental Health Treatment: Mental health treatment records are protected under Federal and State laws and regulations and cannot be disclosed without your written authorization unless otherwise allowed in Federal or State laws or regulations. To release mental health treatment information, this authorization must include a statement of the specific information that you are giving the Agency permission to disclose (for example, "For the purposes of my assessment, treatment plan, attendance, or discharge plan.") Disclosure of your psychotherapist's notes needs separate written permission. Re-disclosure of your mental health treatment records is not allowed except in compliance with law or with your written permission. **To NOT INCLUDE this information, initial here** _____