

## **Communication Directive Form Instructions**

Attached is a copy of Capital Health Plan's Communication Directive form. This form enables you to designate an individual, or individuals, with whom CHP may discuss your medical care and will allow verbal release of your protected health information to a family member, close friend or other person identified by you.

## **INSTRUCTIONS:**

- Member Name: Enter the name of the member whose information will be released.
- Enter the names of those you wish to designate on the accompanying lines
- Check all that apply, initial, and date the statement indicating that you are aware that this would include any and all of your health care information including mental health, alcohol and/or drug abuse, HIV/AIDS testing or diagnosis, Sexually Transmitted Diseases and genetic disorders.

The next paragraph further explains that this form allows discussion of your health care only. It does not allow anyone to receive copies of your medical records. You may cancel this directive at any time with a written request to revoke in writing.

Parents do not need to complete Communication Directives for their children under 18 years of age to be able to discuss your child's care with the physician, unless you wish to have someone else designated to discuss your child's care. If a minor over 12 years of age is treated for confidential reasons, the child will need to complete a Communication Directive form if he/she wish to have this information discussed with a parent.

## **PLEASE:**

- Date and sign the form
- Include the member's date of birth
- Include the member's CHP number
- Legal Representatives must print his/her name (If applicable)
- Add the last four (4) digits of the member's social security number
- Return signed form to:

Capital Health Plan – Medical Records P.O. Box 15349 Tallahassee, Fl. 32317 - 5349

If you need help, please call 850-383-3311 (TTY 1-877-486-2048), Monday through Friday, 8:00 a.m. - 5:00 p.m. Medicare members should call 1-850-523-7441 or 1-877-247-6512 (TTY 850-383-3534 or 1-877-870-8943) 8:00 a.m. – 8:00 p.m., seven days a week, October 1 – March 31; 8:00 a.m. – 8:00 p.m., Monday – Friday, April 1 – September 30.

State of Florida members call 1-877-392-1532, 7:00 a.m. –7:00 p.m.



## **COMMUNICATION DIRECTIVE FORM**

This Communication Directive authorizes Capital H	ealth Plan to release (or disclose) <b>verbal information</b>
	nent from the medical records or billing records of
(Member Name)	to the following:
Name:	
I understand that the extent or nature of the medica medical records. I consent to any and all medical ar (check all that apply)*:	l information to be released includes any and all ad billing record information being released including
<ul> <li>☐ Mental Health</li> <li>☐ HIV/AIDS Testing, Treatment, Diagnosis</li> <li>☐ Genetic Disorders</li> <li>Initial &amp; Date</li> </ul>	☐ Alcohol and/or Drug Abuse Treatment ☐ Sexually Transmitted Diseases
I also understand that the purpose or need for this re	elease is to assist in communication of my medical by be cancelled. It will remain in force until such time erbal information and does not authorize release of
Prohibition of Disclosure: The protected health infordoes not authorize Capital Health Plan to release th	
Date	
Member/Legal Representative Signature	Date of Birth
Member CHP#	
Legal Representative Name (If Applicable)	
Last four (4) digits of member's Social Security Num	ber
*Minors over the age of twelve (12) must sign and au	thorize the release of information in this section.
45 CFR, 164.510 (b) and 165.522	

Revision History

Compliance Committee Approved Date: 2/25/2003, 8/24/2025

Reviewed Only: 2/16/2010, 11/19/13, 8/19/2014, 8/25/2015, 5/24/2016, 12/6/2018, 9/17/2019 Revised: 12/21/2004, 8/21/2007, 2/21/2012, 4/30/2013, 05/28/2020, 8/24/2025

Policy Location (s): Compliance Intranet – Compliance Forms, CHP Public Website