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

IMPORTANT REMINDER

The final section relates to the revocation (cancellation of the above designations). This is to be signed at a future date only if you decide that the person/persons noted above may no longer be able to discuss your health care with CHP personnel.

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.

Revision History
Approved by: Compliance Committee Approved Date: 8/21/2007 Reviewed Only With No Changes : 8/25/2015, 5/24/2016
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Policy Location (s): Compliance Intranet – Compliance Policies

Capital Health PLAN

An Independent Licensee of the Blue Cross and Blue Shield Association

COMMUNICATION DIRECTIVE FORM

This Communication Directive authorizes Capital Health Plan to release (or disclose) **verbal information relating to identity, diagnosis, prognosis, or treatment from the medical records or billing records of** _____ to the following:

(Member Name)

Name: _____
Name: _____
Name: _____
Name: _____
Name: _____

I understand that the extent or nature of the medical information to be released includes any and all medical records. I consent to any and all medical and billing record information being released including (check all that apply)*****:

Mental Health

Alcohol and/or Drug Abuse Treatment

HIV/AIDS Testing, Treatment, Diagnosis

Sexually Transmitted Diseases

Genetic Disorders

Initial/Date _____

I also understand that the purpose or need for this release is to assist in communication of my medical care. Furthermore, I understand that this release may be cancelled. It will remain in force until such time as it is cancelled by myself. I understand this is for verbal information and does not authorize release of medical records, which would require a separate written authorization.

Prohibition of Disclosure: The protected health information to be released is confidential. This directive does not authorize Capital Health Plan to release this information to any other party.

Date _____
Member/Legal Representative Signature _____ Date of Birth _____
Member CHP# _____
Legal Representative Name (If Applicable) _____
Last four (4) digits of member's Social Security Number _____

***Minors over the age of twelve (12) must sign and authorize the release of information in this section.**

Cancellation Section:

I hereby revoke the designation of this individual to receive protected health information.

_____ _____
Member Signature Date

45 CFR, 164.510 (b) and 165.522

Revision History
Compliance Committee Approved Date: 2/25/2003
Reviewed Only: 2/16/2010, 11/19/13, 8/19/2014, 8/25/2015, 5/24/2016, 12/6/2018, 9/17/2019
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Policy Location (s): Compliance Intranet – Compliance Forms, CHP Public Website