



Communication Directive Form Instructions

Attached is a copy of Capital Health Plan's (CHP) 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 name(s) of those you wish to designate as authorized individuals.
- 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 are not required to complete a Communication Directive for children under 18 yrs of age in order to discuss their child's care with the physician, unless they wish to authorize an additional individual to participate in those discussions and/or have access to their child's information. However, if the minor, under applicable Federal or State law, has the right to authorize the use or disclosure of their protected health information, the minor must complete and sign the Communication Directive form before information can be shared with anyone else, including a parent.

PLEASE:

- Date and sign the form. If signing electronically, please provide a copy of your driver's license/State ID
- 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 1-877-8708943) 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 Health Plan to release (or disclose) verbal information relating to my identity, diagnosis, prognosis, treatment, or billing information to the individual(s) listed below. I also understand that the purpose or need for this release is to assist in communication of my medical care. This Directive does not authorize the release, inspection, or copying of medical records. A separate HIPAA-compliant written authorization, as required under 45 CFR §164.508, must be used for medical record disclosures.

Authorized Individuals:

Name	Relationship

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 and initial all that apply)**:

Category	Category
<input type="checkbox"/> Mental Health (FS 394.4615, FS 394.4784)*	<input type="checkbox"/> Genetic Disorders*
<input type="checkbox"/> HIV/AIDS Testing, Treatment, Diagnosis (FS 381.004)*	<input type="checkbox"/> Sexually Transmitted Diseases (FS 384.29–384.31, FS 381.0051)*
<input type="checkbox"/> Maternal Health (FS 743.065)*	<input type="checkbox"/> Alcohol/Substance Use Disorder (FS 397.501; 42 CFR Part 2)*
<input type="checkbox"/> None of the Above*	Initial: Date:

***For minors who are legally authorized to consent to the disclosure of their protected health information, the minor’s signature is required to authorize the release of information under this Authorization.**

This Communication Directive remains in effect until revoked or until I am no longer enrolled with Capital Health Plan. I understand I may revoke this Communication Directive at any time in writing (45 CFR §164.508(b)(5)). Revocation does not affect disclosures already made prior to the revocation.

Member Name (Print):	Member/ Legal Representative Signature:	Date:
Member/ Legal Representative Name (If Applicable):	Member CHP ID#:	
Member Last Four (4) digits of Social Security Number:		

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.