Capital Health PLAN

An Independent Licensee of the Blue Cross and Blue Shield Association

COMMUNICATION DIRECTIVE FORM

I,_____, authorize Capital Health Plan to release (or disclose) **verbal information from my medical records or billing records** relating to my identity, diagnosis, prognosis, or treatment to:

Spouse Name: _____
Child Name:_____
Sibling Name: _____
Other Name: _____
Other Name: _____

I understand that the extent or nature of the medical information to be released includes any and all medical records, including **MENTAL HEALTH, ALCOHOL, AND/OR DRUG ABUSE TREATMENT AND HIV (AIDS) TESTING, TREATMENT OR DIAGNOSIS SEXUALLY TRANSMITTED DISEASES AND GENETIC DISORDERS, UNLESS YOU INSTRUCT OTHERWISE.**

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.

SPECIAL INSTRUCTIONS OR RESTRICTIONS REQUESTED BY MEMBER:

_____

_____

DATE _____

MEMBER SIGNATURE _____ DATE OF BIRTH _____

PRINTED NAME OF MEMBER _____ CHP# _____

LAST FOUR (4) DIGITS OF SOCIAL SECURITY NUMBER _____

OR

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
Approved by: Compliance Committee Approved Date:2/25/2003
Reviewed Only With No Changes: 2/16/2010, 11/19/13,8/19/2014,8/25/2015, 5/24/2016
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