



Florida Blue
P.O. Box 45296
Jacksonville, FL 32232

AUTHORIZATION FOR DISCLOSURE OF PHI RECORDS

You, as a member, or acting as a personal representative of a member, of Blue Cross and Blue Shield of Florida, Inc., Health Options, Inc., or Florida Blue Medicare, Inc. ("Florida Blue") or Truli for Health, can authorize the disclosure of your protected health information in certain records ("**PHI Records**") with the people or companies listed below. Please complete all sections of this form and then return the signed form to the address listed above.

1. Member Information (Individual whose PHI Records will be disclosed):

Member contract number		Date of birth	
Member first name		Middle initial	
Member last name			
Address			
City		State	Zip code
Telephone number			

2. I authorize the disclosure of my PHI Records to the following people or companies:

Person or company name Legal-Ease Digital Imaging, LLC		
Address 2496 Meadowcroft Dr		
City Burton	State M.I.	Zip code 48519
Telephone number PH: 855-543-4003 FX: 810-547-4030 pat.legalease@gmail.com		

Health insurance is offered by Florida Blue. HMO coverage is offered by Florida Blue HMO, Truli for Health and Florida Blue Medicare, Inc., which are affiliates of Florida Blue. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.

3. I authorize the disclosure of my PHI Records for the following purpose:

Please check **ONLY ONE** box:

☐ At my request – no specific purpose ☒ Specific purpose: Litigation

Example: Help me administer my health insurance benefits

4. I authorize the disclosure of the following PHI records:

Please check **ONLY ONE** box:

☐ A claim summary report listing the provision of, and payment for, my health care benefits or services.

☐ Specific information as described on the line below:

Example: The claim related to my service on (date).

5. My authorization to disclose PHI Records will expire:

Please check **ONLY ONE** box:

☐ When I revoke this authorization in accordance with the instructions listed below

OR

☐ Upon the following date, event or condition:

6. By signing below, I understand and agree:

- My PHI Records may contain information created by other persons or entities, including health care providers, and may include sensitive diagnosis and treatment information covering chronic diseases, behavioral/mental health conditions, substance use disorders, HIV/AIDS and other infectious diseases.
- If I share my PHI Records with persons outside of Florida Blue or Truli for Health, they may not be subject to state or federal privacy laws restricting its use or disclosure.
- I can get a copy of this authorization form that I have signed by sending Florida Blue a signed written request using the address at the top of this form.
- I may revoke this authorization at any time by notifying Florida Blue in writing using the address at the top of this form, however, the revocation will not have any effect on any actions taken prior to the date that my revocation is received and processed.
- This authorization is voluntary; my enrollment or eligibility for benefits with Florida Blue or Truli for Health won't change if I do not sign this form.

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Sign
Here

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Date

MM/DD/YYYY

☐ Check here and complete the Personal Representative Information section below if you are signing this form as a personal representative of the Florida Blue or Truli for Health member.

Personal Representative Information: If the member can't sign this form, a personal representative may sign, complete and return this form for the member. A personal representative is someone who has the legal right to sign this form on behalf of the member. **Please attach proof that you are the member's personal representative (for example, Power of Attorney). We can't accept this form without this documentation.**

First name		Last name	
Address			
City	State	Zip code	
Telephone number			

If you have any questions regarding this form, please call Customer Service at the toll-free number on the back of your member identification card.