Authorization for Release of Protected Health Information

The account information of a Florida KidCare enrollee (child), including personal identifying information relating to the enrollee (child) and the applicant (Parent 1 or Parent 2), is protected under federal and Florida law. As such, the Florida Healthy Kids Corporation can only disclose such protected information to the enrollee (child) or the applicant (Parent 1 or Parent 2) listed on the account.

To give us permission to (i) discuss an enrollee and/or applicant's information with someone else and/or (ii) release an enrollee and/or applicant's information with someone else, please complete this form. An emancipated child or child 18 years of age or older must complete the form before we can discuss his or her account with anyone else.

If you need help completing this form, please call 1-888-540-5437. All fields required.

A. Applicant information (Parent 1 or Parent 2 on the account):		
First Name	Last Name	
Family Account Number	Phone (Home or Cell)	
Street Address	Apartment Number	
City	State	ZIP Code
Email Address		

B. Enrollee whose protected information may be disclosed:		
1. First Name	Last Name	Date of Birth
2. First Name	Last Name	Date of Birth
3. First Name	Last Name	Date of Birth

C. I authorize the Florida Healthy Kids Corporation to release or discuss protected information with the below person or organization:			
Name	Phone		
Address	City	State	ZIP Code
Email Address:			

D. I authorize the Florida Healthy Kids Corporation to release the following protected information to the person in C, above:

☐ All account information

☐ Only eligibility and enrollment records (examples: applications, letters, screen prints and account notes)

☐ Only premium amount, due date, and when payments are received

☐ Only insurance company information (examples: name of the health or dental plan and dates the enrollee is covered)

☐ Other. Describe:

E. I authorize the Florida Healthy Kids Corporation to disclose and release the protected health information checked in D, above, for the following purposes:

☐ To help me with the account

☐ For legal help

☐ When the person asks for information

☐ Language translation

☐ Other. Describe:

F. My rights:

- I understand that the information to be disclosed contains personal identifying information, including but not limited to names, addresses, telephone numbers, Social Security numbers, health care information, and/or reemployment compensation information.
- I understand that personal identifying information is protected under federal law and Florida law, including but not limited to sections 409.821 and 443.1715, Florida Statutes; the Health Insurance Portability and Accountability Act; and/or 20 CFR Part 603.
- I understand that authorizing the disclosure of this protected information is voluntary and you have my consent to release all records for all dates including all diagnostic tests of any type and reports, history, hospitalization, diagnosis, prognosis, treatment, medication and pharmacy records, correspondence, consults, statement of charges or expenses, and any and all reports of any type or character.
- I understand that once the person named in C above receives my and/or the enrollee’s information, he or she may not protect it, or the information may be re-disclosed. I will not hold the Florida Healthy Kids Corporation liable if that person re-discloses or fails to protect any protected information.
- I understand that I may revoke this authorization before its expiration date by notifying the Florida Healthy Kids Corporation privacy officer. This revocation will not affect any actions taken before receiving the cancellation.
- I understand I do not have to sign this authorization to obtain health care benefits (treatment, payment, or enrollment).
- I understand the any health care information may relate to testing, diagnosis, and/or treatment for HIV (AIDS Virus), sexually transmitted diseases, psychiatric/mental health disorders, communicable or non-communicable diseases, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS Virus), sexually transmitted diseases, psychiatric/mental health disorders, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.
- I understand that this authorization will expire as stated in G, below. After that, I must complete a new form to authorize the Florida Healthy Kids Corporation to disclose the enrollee’s and/or my personal identifying information to someone else.

• I hereby consent to the disclosure of my information and/or the information of the enrollee(s) identified in B, above.	
G. Expiration:	
This authorization will expire one year from the date you signed this form (below). If you wish the authorization to end sooner than that, please enter that date: ________________.	
Signature of Person Named in A, above	**Date**

Keep a copy of this form for your records. Mail the completed and signed form to:

Florida Healthy Kids Corporation
P.O. Box 980
Tallahassee, FL 32302

Or scan and email the completed and signed form to contactus@healthykids.org.