Authorization for Release of Protected Health Information

People First and Chard Snyder, serving you on behalf of the State Group Insurance Program ("Program"), cannot use or disclose[1] protected health information (or the health information of your children or other people on whose behalf you can act) without the appropriate authorization. This means we are not permitted to discuss or provide to any person, including your spouse, any information concerning your health insurance, health care flexible spending account, or health savings account, as applicable.

To allow us to disclose your information to the person or organization of your choice, please complete the form below and return as directed on the last page of the form.

- If you wish to authorize us to discuss your protected health information with more than one person, you must complete a separate form for each person.
- If you wish to authorize us to discuss protected health information for your covered dependent(s) on whose behalf you can act, you must complete a separate form for each dependent.
- If your covered dependent(s) over the age of eighteen wishes to authorize us to discuss their protected health information, they must complete a separate form.
- If you have a valid medical power of attorney and you want to authorize him or her to receive your protected health information, you are not required to complete this form; however, you must send a copy of the valid medical power of attorney to provide authorization for disclosure.

Note: this form only authorizes People First and/or Chard Snyder to disclose your information. Your health plan, CVS/caremark, and healthcare provider each have separate authorization forms.

For assistance with completing this form, please call People First at 866-663-4735.

1. PERSON COMPLETING FORM		
First Name*	Last Name*	
People First ID Number*	Date of Birth (mm/dd/yyyy)*	
Primary Phone*	Secondary Phone	
Email Address		
Street Address*		
City*	State*	ZIP Code*

*required

2. PERSON WHOSE PROTECTED HEALTH INFORMATION MAY BE DISCLOSED (separate form required for each person)
☐ Self
☐ Dependent on whose behalf you may act
FIRST NAME _____ LAST NAME _____

[1] Except as permitted under federal law (HIPAA) and as described in the Program's privacy notice, available at myBenefits.myFlorida.com.

3. PERSON OR ORGANIZATION AUTHORIZED TO RECEIVE/DISCUSS PROTECTED HEALTH INFORMATION			
Name	Phone		
Address	City	State	ZIP Code
Relationship to You ☐Spouse ☐Adult Child ☐Parent ☐Friend ☐Legal Representative ☐Other _____			
Purpose:			

4. INFORMATION TO BE RELEASED TO RECIPIENT NAMED IN #3 ABOVE

Check all that apply:

I hereby authorize **People First** to disclose protected health information recorded in the People First system for the person named in #2 above as indicated:

☐All account information recorded in the People First system

☐Enrollment information ☐Premium Payment information

☐Benefit information ☐Dependent information

Authorization to disclose protected health information expires:

☐ On the following date: _____

☐ Upon disenrollment from the Program.

I hereby authorize **Chard Snyder** to disclose the protected health information related to my flexible spending account (FSA) and/or my health savings account as indicated below. You MUST check the appropriate box:

☐ Healthcare FSA; and/or ☐ Health Savings Account

Authorization to disclose protected health information expires:

☐ On the following date: _____

☐ Upon disenrollment from the Program.

5. IMPORTANT INFORMATION ABOUT PARTICIPANT'S RIGHTS

☐ I have read and understand the following statements about my rights:

- This authorization is voluntary and I may refuse to sign this authorization.
- I am not required to sign this form to receive my health care benefits.
- The information used or disclosed pursuant to this authorization may be redisclosed by the recipient named in #3 above. I have the right to seek assurances from such recipient that he/she will not redisclose the information to any other party without my further authorization. Neither People First nor Chard Snyder will be held liable for any redisclosure of protected health information by such recipient.
- I may revoke this authorization at any time prior to its expiration date by notifying People First in writing, but the revocation will not have any effect on any actions that People First or Chard Snyder took before receiving the revocation notice.
- I understand this authorization will expire as stated above and I will need to complete a new form to allow individuals authorization to my protected health information.
- By authorizing Chard Snyder to disclose information related to my healthcare FSA and/or my health savings account, my records may include information regarding drug or alcohol use, counseling referrals and/or a history of testing or treatment of acquired immune deficiency syndrome (AIDS) or related conditions.

AUTHORIZATION AND SIGNATURE	
Signature of Person Named in #1 Above*	Date*
Printed Name	

SUBMISSION
Keep a copy for your records and send the completed form to: People First Service Center PO Box 6830 Tallahassee, FL 32314 -OR- Fax to (800) 422-3128

*LEGAL REPRESENTATIVE
No additional documents are required, as long as the person signing this form is acting for himself or herself or has the authority to act on behalf of a dependent. If the person is unable to sign this form for any of the following reasons, the person's legal representative must provide one of the following and complete the information below: 1. If the person is deceased, the legal representative must provide documentation that he or she is the executor or administrator of the participant's estate. We may not rely on a durable power of attorney, advance directive, guardianship or conservatorship papers after the death of the person, as the papers are not valid after death. 2. If the person is incapacitated and, as a result, a legal representative needs to act on behalf of the person, submit this completed authorization form and include the legal documentation showing who the legal representative is. Legal documentation includes durable power of attorney, guardianship or conservatorship papers.

First Name of Person's Legal Representative	Last Name of Person's Legal Representative	
Primary Phone of Person's Legal Representative	Email Address of Person's Legal Representative	
Street Address of Person's Legal Representative		
City	State	ZIP Code