



Authorization for Mental Health Providers to Release Medical Information

This authorization is at my request to permit the release of mental health clinical information to Blue Cross and Blue Shield of Florida, Inc., Health Options, Inc. and their Business Associates (together, BCBSF).

Section I: Physician, Hospital, Provider, Facility Authorized to Release my Medical Information

Name		
Street Address		
City	State	Zip

Section II: Patient Information

I hereby voluntarily authorize physician(s), hospital(s), other health care providers, health care agencies, named in Section I possessing medical information to release this information to BCBSF. This voluntary authorization includes, without limitation, the release of past, present or future: mental health clinical information that may also include, alcohol and drug abuse treatment, psychological/psychiatric testing and evaluation information, and other information regarding medical diagnosis, treatments and/or conditions.

Patient Name	Date of Birth (MM/DD/YYYY)
Subscriber Name	Contract Number/Member ID Number

Section III: Expiration

This voluntary authorization expires six months from the date of this release unless otherwise indicated or revoked earlier.

This authorization will expire: _____ / _____ / _____
Month Day Year

OR

The date patient's BCBSF health coverage ends: _____ / _____ / _____
Month Day Year

Section IV: Copy of Authorization

Please keep a copy of your signed voluntary authorization. A photocopy is as valid as the original.

Section V: Right to Withdraw Authorization

I understand that I may withdraw this voluntary authorization at any time by giving written notice to the office listed on page 1. I further understand that withdrawal of this voluntary authorization will not affect any action taken by BCBSF in reliance on this voluntary authorization prior to receiving my written notice of withdrawal.

Section VI: Signature

Patient's Signature: _____ Date: _____

If a legal representative signs this voluntary authorization form on behalf of the patient, please complete the following:

Legal Representative's Name: _____ Relationship to the Patient: _____
(please print)

Legal Representative's Signature: _____ Date: _____