

Authorization For Release of Protected Health Information

Complete this form to authorize Vista Healthplan, Inc., Vista Healthplan of South Florida, Inc. or Vista Insurance Plan, Inc. to release your protected health information. **INCOMPLETE FORMS WILL NOT BE ACCEPTED.**

GENERAL INFORMATION

Please print the following information:

Name _____ Member Number: _____

Street Address _____ City _____

State _____ Zip Code _____ Phone Number (_____) _____ - _____

ACKNOWLEDGMENT

I _____ (Print Name) hereby authorize VISTA to use or disclose my health information as described in this authorization. I understand that:

- I have the right to revoke this authorization at any time by notifying the Privacy Officer in writing at 300 South Park Road, Hollywood FL 33021. I understand that the revocation is only effective after it is received and logged by Vista Healthplan, Inc., Vista Healthplan of South Florida, Inc. or Vista Insurance Plan, Inc. I understand that any use or disclosure under this authorization made prior to a subsequent revocation will not be affected by any such revocation.
- After this information is disclosed, federal law might not protect it and the recipient might re-disclose it.
- I am entitled to receive a copy of this authorization.
- This authorization will be maintained by the Plan for a period of six (6) years from the date it was last in effect.
- The member (or Personal Representative of Member) is voluntarily signing this authorization, and understands that refusal to authorize disclosure of member's personal medical information will have no effect on member's enrollment, eligibility, or health benefits received.

This authorization is in effect from _____ to _____. Upon the conclusion of that time period, this authorization is automatically revoked.

PROTECTED HEALTH INFORMATION REQUEST INSTRUCTIONS

List the name of or describe the specific person/organization (or class of persons) authorized to receive the information:

Provide a specific description of the information authorized for release. **Circle all that apply.**

Claims Inquiry	Enrollment/Eligibility	Explanation of Benefits
Case Management	Disease Management	Pharmacy Information
PCP Changes	Other: _____	Discharge Planning

PURPOSE STATEMENT. Provide the purpose of the request below. (If you do not wish to state a purpose, please state, "At my request."): **This section must be completed.**

Signature of Member _____ Date ____/____/____

If anyone other than Member (i.e., Personal Representative):

Printed Name: _____ Signature: _____ Date ____/____/____

Describe authority to act on member's behalf: _____

MAIL AND FAX INSTRUCTIONS

Send completed Authorization to:

VISTA. Attention: _____ (insert name of person or department)

1340 Concord Terrace, Sunrise FL 33323 or Fax to _____.

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