COMMUNICATION DIRECTIVE FORM

I, ___________________________, authorize Capital Health Plan to release (or disclose) **verbal information from my medical records or billing records** relating to my identity, diagnosis, prognosis, or treatment to:

Spouse Name: ____
Child Name: ____
Sibling Name: ____
Other Name: ____
Other Name: ____

I understand that the extent or nature of the medical information to be released includes any and all medical records, including **MENTAL HEALTH, ALCOHOL, AND/OR DRUG ABUSE TREATMENT AND HIV (AIDS) TESTING, TREATMENT OR DIAGNOSIS.**

Initial/Date ___________

I also understand that the purpose or need for this release is to assist in communication of my medical care. Furthermore, I understand that this release may be cancelled. It will remain in force until such time as it is cancelled by myself. I understand this is for **verbal information and does not authorize release of medical records** which would require a separate written authorization .
PROHIBITION OF DISCLOSURE: The protected health information to be released is confidential. This directive does not authorize Capital Health Plan to release this information to any other party.

SPECIAL INSTRUCTIONS OR RESTRICTIONS REQUESTED BY PATIENT:

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DATE _____________

PATIENT SIGNATURE __________________________ DATE OF BIRTH ______________

PRINTED NAME OF PATIENT ____________________ CHP# _______________________

LAST FOUR (4) DIGITS OF SOCIAL SECURITY NUMBER ___________________________

OR

CANCELATION SECTION:
I hereby revoke the designation of this individual to receive protected health information.

____ ______________________
Patient Signature Date

45 CFR, 164.510 (b) and 165.522

Approved by Compliance Committee 2/25/2003, revised and approved 12/21/04, Revised/approved 8/21/07, Reviewed and approved by Compliance Committee 2/16/10