Florida
Authorization to share protected health information (PHI) and/or personally identifiable information (PII)

Purpose: The purpose of this authorization is to permit Medicare to release to a third party, such as someone other than the beneficiary or Medicare provider (provider), protected health information and/or personally identifiable information, specific to Medicare records and/or claim information.

Section I:

Provide the following information regarding the beneficiary or provider whose PHI/PII is to be disclosed. **(Please type or print).**

Name:

Address 1: Address 2:

City: State: FL ZIP code:

Telephone: Daytime: Evening:

Date of birth: Medicare or provider number:

Section II:

I hereby authorize Medicare to share the following PHI/PII:

☐ Identifying information (e.g., name, address, age, gender)

☐ Health care coverage information

☐ Claim information for date(s) to

☐ Past, present and future claim information

Section III:

Identify the person(s) or organization(s) with whom Medicare may share PHI/PII.

Name:

Address 1: Address 2:

City: State: FL ZIP code:

Medicare Freedom of Information
(904) 791-6605

Section IV:

Enter a date OR select an event upon which you want this authorization to expire.

○ This authorization will expire: _____ OR

○ When Medicare coverage/privileges ends

Section V:

You have the right to "take back" (revoke) your authorization at any time, in writing, except to the extent that Medicare has already acted based on your permission. To revoke your authorization, send a written request to:

JN Part A and B FOIA requests
P.O. Box 3425
Mechanicsburg, Pa 17055-1825

I understand refusal to authorize disclosure of my PHI/PII will have no effect on enrollment, eligibility for benefits, billing privileges, or the amount Medicare pays for the health services I receive/render.

PHI/PII that you authorize Medicare to disclose may be subject to redisclosure and no longer protected by law.

A photocopy of this authorization is as valid as the original.

Signature:

Beneficiary or provider signature: _____ Date: _____

If someone else is signing this authorization form on behalf of the beneficiary or provider, provide the following information:

Legal Representative**

Name: _____

Signature: _____ Date: _____

Relationship to beneficiary or provider:

(**Documentation must be provided to support your status as a guardian or other legal representative)

This authorization form must be accompanied by a signed and dated cover letter from your office.

Complete the entire form and return with a written request to:

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Print Reset

Modified: 9/14/2020

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