VISTA HEALTHPLAN OF SOUTH FLORIDA
MEDICAL RECORDS RELEASE AUTHORIZATION FORM

Please leave this form with the Applicant.
Applicant may present this form to the physician when requesting medical records.

Applicant Tracer # _____

In order to be considered for Individual medical coverage, the applicant listed below is required to submit copies of medical records with his or her application. The cost for obtaining medical records is the responsibility of the applicant, as **Vista Healthplan of South Florida does not pay for the retrieval of medical records**.

Medical records should include copies of the provider's chart as well as the results of any laboratory or diagnostic tests performed in the last 24 months.

Applicant: _____ Social Security #: _____

Applicant's Authorization for Release of Medical Records

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or other organization, institution or person, that has any records or knowledge of me or my health, or any legal dependents to release such information to Vista Healthplan of South Florida.

This release specifically includes but is no limited to authorization to release any medical records and information associated with (or in reference to) the following conditions: Positive exposure to HIV infection, ARC, AIDS, alcohol or drug dependency, mental and nervous disorders.

A photographic copy of this authorization shall be as valid as the original.

Dated at _____ this _____ day of _____, 20_____

Signed _____
(Applicant's Signature or Parent of Applicant under the age of 18)

Attach medical records to the Individual Enrollment Application or if the Individual Enrollment Application has been sent to the plan mail the records to:

Vista Healthplan of South Florida
Individual Medical Underwriting
300 S. Park Road
4th Floor - Underwriting Department
Hollywood, FL 33021