

**ELECTRONIC DATA INTERCHANGE RELEASE (EDI)  
OR RELEASE FOR ACCESS TO HCHCP DATA  
FOR AGENTS OF HILLSBOROUGH COUNTY HEALTH CARE SERVICES**

The following Agency/Contractor/or other authorized entity named below:

\* \_\_\_\_\_ is hereby authorized to obtain data from, or have access to information database(s) of Hillsborough County Health Care Services Department for the purpose of verifying membership, authorizations or claims data specific to Hillsborough County HealthCare Plan (HCHCP).

**ACTUAL PURPOSE AND INTENT FOR THE ACCESS:**

**ACES Provider Eligibility Verification Access ONLY.**

*Protocols set up by the County shall be applicable to all data file transfers. Information specific to data transfers will only be relayed to named Agents/Contractors or their designated representatives listed below:*

**DESIGNATED REPRESENTATIVE/S to whom access or file transfer rights will be given:**

\*Organization: \_\_\_\_\_ NPI/TIN#: \_\_\_\_\_

\*Authorized Rep: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

\*E-Mail Address: \_\_\_\_\_

\*Supervisor of Authorized Rep: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

\*E-Mail Address: \_\_\_\_\_

\*Business Location Mailing Address: \_\_\_\_\_  
3/10/23 \_\_\_\_\_

Start date for Access: \_\_\_\_\_ Expiration date: \_\_\_\_\_ /Or end of Contract:

\* Name of Hillsborough County Contact: \_\_\_\_\_

IF FOR ANY REASON THE DESIGNATED REPRESENTATIVE CHANGES, IT IS THE RESPONSIBILITY OF THE AGENT/CONTRACTOR/OR OTHER AUTHORIZED ENTITY NAMED ABOVE TO IMMEDIATELY NOTIFY THE HCHCP CONTACT PERSON.

**NOTICE; Confidential information including but not limited to medical information, mental health information, HIV status, eligibility for Federal entitlement programs such as Social Security, Medicaid, Medicare, Veterans benefits, Transportation Disadvantaged, Community Services Block Grant, Ryan White or any other information designated as confidential pursuant to State or Federal Law shall be held as such and used only in a lawful manner for the express purpose named above and/or for providing medical care to patients of the Hillsborough County HealthCare Plan. Adherence to all HIPAA regulatory governing statutes must be strictly applied with respect to HCHCP information obtained or entered. The County reserves the right to revoke access for non-compliance with confidentiality regulations and prevailing governing statutes.**

**Signature of Authorized Agent/Contractor or Other Entity:**

\*Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

\*Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**For Internal County Use Only**

AUTHORIZING SIGNATURE FOR HCHCP: \_\_\_\_\_ Date: \_\_\_\_\_