South Carolina

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO A THIRD PARTY

1. Member Information: Individual whose information may be disclosed.

Name: _____ Date of Birth: _____ Telephone Number: _____

Mailing Address: _____

Member ID#: _____

2. Authorization: I authorize BlueCross BlueShield of South Carolina to disclose the above listed member's protected health information to the following individual/entity in the manner described in Section 3 below.

Name: _____

Mailing Address: _____

Telephone: _____ Relationship: _____

3. Scope of Authority. I authorize the disclosure of my protected health information to the above-named individual/entity as follows: (check only one)

☐ I authorize BlueCross to disclose any protected health information (except psychotherapy notes) that the above-named individual/entity may request. If applicable, this information may include information pertaining to chronic diseases, behavioral health conditions, communicable diseases including HIV or AIDS, and/or genetic information.

_____ Also include any alcohol and substance abuse records, if applicable. * ***(indicate by initialing)***

*This authorization will not apply to alcohol or substance abuse information unless specifically authorized above.

☐ I authorize BlueCross to disclose ONLY the following protected health information to the above-named individual/entity:

_____

_____

4. Purpose. This authorization is made:

☐ At my request.

☐ For the following purpose(s): _____

5. Expiration and Revocation.

Expiration: This authorization will expire on ____/____/_____ or 12 months after termination of my coverage under BlueCross, whichever occurs first.

Revocation: I understand that I may revoke this authorization at any time by sending written notice of my revocation to the address shown below.

Please note: I understand that revocation of this authorization will *not* affect any action taken by BlueCross in reliance on this authorization before my written notice of revocation was received.

6. Signature. (Any individual age 16 or over who wishes to grant authorization must complete their own individual authorization form.)

I am making this authorization voluntarily and have had full opportunity to read and consider the contents of this authorization. I understand that BlueCross will not condition my enrollment in a health plan, eligibility for benefits, or payment of claims upon my signing this authorization. I further understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Signature: _____ Date: _____

Personal Representative's Signature: _____ Date: _____

If this authorization is completed by a personal representative on behalf of the individual, the personal representative must **attach legal documentation** establishing authority to act as the individual's personal representative.

Please return this form to: Attn: Vinnetta Osborne, HIPAA Privacy Official (AX-G50)
P.O. Box 100300
Columbia, South Carolina 29202
(803) 736-8983 (fax number)

If you have any questions, please call Customer Service at the number on the back of your ID card.