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: **(select only one)**

   ☐ BlueCross may 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. Please initial here _____ to also include any alcohol and/or substance use records.

   OR

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

   _____

   Please initial here _____ to also include any alcohol and/or substance use records.

4. **Purpose.** This authorization is made: (Check only one)

   ☐ At my request

   OR

   ☐ For the following purpose(s) (i.e. civil litigation, workman's compensation claims, etc.):

   _____

5. **Expiration and Revocation.**

   Expiration: This authorization will expire on _____/_____/_____.
   If no date is indicated above, expiration will be 12 months after termination of my coverage with BlueCross.

   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 his or her 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:
Vinnetta Osborne, Compliance Manager (AX-175)
P.O. Box 100300
Columbia, SC 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.