

**AUTHORIZATION TO DISCLOSE
 PROTECTED HEALTH INFORMATION TO A THIRD PARTY**

1. Authorization. I authorize BlueCross BlueShield of South Carolina to disclose my protected health information to the following individual/entity in the manner described in Section 2 below.

Name: _____

Address: _____

Telephone: _____ Relationship: _____

**2. 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 BlueShield of South Carolina 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*)

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

3. Purpose. This authorization is made:

At my request.

For the following purpose(s): _____

4. Expiration and Revocation.

I understand that I may revoke this authorization at any time by providing written notice of my revocation to BlueCross at the address listed below. 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.

I understand that this authorization will expire 12 months after termination of my coverage with BlueCross, unless earlier revoked by me or my personal representative.

5. Signature. (A separate form must be completed by any individual age 16 or over who wishes to grant authorization.)

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: _____

Print Name: _____ Member ID Number: _____

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

Personal Representative's Name: _____ Signature: _____

Please return this form to: BlueCross BlueShield of South Carolina
 Attn: Vinnetta Osborne, HIPAA Privacy Official (AX-G50)
 P.O. Box 100300
 Columbia, South Carolina 29202
 (803) 264-4588 (phone number)
 (803) 736-8983 (fax number)

*This authorization will not apply to alcohol or substance abuse information unless specifically authorized under Section 2.