



BlueCross BlueShield of South Carolina

An independent licensee of
Blue Cross and Blue Shield Association

AUTHORIZATION FOR PROVIDER TO DISCLOSE PROTECTED HEALTH INFORMATION TO BLUECROSS BLUESHIELD OF SOUTH CAROLINA

1. **Authorization.** I authorize _____ (“Provider”) to disclose my protected health information to Blue Cross and Blue Shield of South Carolina 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 Provider 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 Provider 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 Provider at the address listed below. I understand that revocation of this authorization will *not* affect any action taken by Provider in reliance on this authorization before my written notice of revocation was received.

I understand that this authorization will expire 24 months from the date signed below, 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 Provider 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 Provider at the following address:

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