



South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

Voluntary Authorization to Disclose Protected Health Information (PHI) to a Third Party

RETURN THIS FORM TO:

BlueCross BlueShield of South Carolina Group & Individual Privacy Official, 120 East at Alpine Road (AX-F10), Columbia, SC 29219-0001 Fax Number: 803-264-0174

SECTION A - MEMBER INFORMATION (INDIVIDUAL WHOSE INFORMATION WILL BE RELEASED):

Primary Member's ID Number (as shown on the member's identification card) or Social Security Number:
Primary Member's Name: (Last, First, Middle Initial) Date of Birth: Telephone Number: (Including Area Code)
Address: (Including ZIP)
Spouse's Name\*/DOB: (if included in authorization)
Dependent's Name\* age 16 or older/DOB: (if included in authorization) Dependent's Name under age 16/DOB: (if included in authorization)

SECTION B - AUTHORIZED PERSON (PERSON OR ORGANIZATION RECEIVING YOUR INFORMATION):

I authorize BlueCross BlueShield of South Carolina to disclose PHI to:
Name: Relationship:
Address: Telephone:
Name: Relationship:
Address: Telephone:

SECTION C - DESCRIPTION OF INFORMATION TO BE RELEASED (TYPE OF INFORMATION THAT WILL BE USED OR DISCLOSED):

Please check only one:
I authorize BlueCross to disclose any PHI (except psychotherapy notes) to the above-named individual/entity that he or she 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 use records, if applicable. (Indicate by initialing)
This authorization will not apply to alcohol or substance use information unless specifically authorized.
I authorize BlueCross to disclose ONLY this PHI:
This authorization is made at my request or for this purpose(s):

SECTION D - EXPIRATION AND REVOCATION (WHEN THIS AUTHORIZATION WILL END):

Expiration: This authorization will expire (choose one):
On \_\_\_/\_\_\_/\_\_\_
12 months after termination of my coverage with BlueCross BlueShield.
Revocation: I understand that I may revoke this authorization at any time by sending written notice of my revocation to the address shown above. 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.

SECTION E - SIGNATURE\*/DATE:

I am making this authorization at my request 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 the Authorized Person may not be subject to federal/state privacy laws and he or she may further release my PHI.
Signature\*: Date:
Spouse's Signature\*: Date:
Dependent Age 16 or Older Signature\*: Date:
Dependent Age 16 or Older Signature\*: Date:
\*If the individual's personal representative signs this authorization, the personal representative must attach legal documentation showing the authority to act on the individual's behalf.

You should keep a signed copy of this authorization for your records; however, we will provide a copy upon your request.