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 Medicare Advantage, I 20 East at Alpine Road (AG-780), Columbia, SC 29219-0001 Fax Number: 803-264-9581

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.