

# BLUECHOICE<sup>®</sup> HEALTHPLAN OF SOUTH CAROLINA, INC.

## Authorization to Disclose Protected Health Information to a Third Party

1. **Authorization.** I authorize BlueChoice HealthPlan 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 BlueChoice HealthPlan to disclose any protected health information (except psychotherapy notes) that the above-named individual/entity may request. I understand the information disclosed may include any information pertaining to chronic diseases, behavioral health conditions, communicable diseases including HIV or AIDS, and/or genetic information that may apply.

\_\_\_\_\_ I also authorize BlueChoice HealthPlan to disclose any alcohol and substance abuse records that may apply.\* *(Indicate by initialing)*

**OR**

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

\_\_\_\_\_  
\_\_\_\_\_

3. **Purpose.** This authorization is made at my request.

4. **Expiration and Revocation.**

I understand that I may revoke this authorization at any time by providing written notice of my revocation to BlueChoice HealthPlan at the address below. I understand that revocation of this authorization will *not* affect any action taken by BlueChoice HealthPlan in its reliance upon 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 BlueChoice HealthPlan, unless earlier revoked by me or by my personal representative.

5. **Signature.** *(A separate form must be completed by each 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 BlueChoice HealthPlan 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 the individual's personal representative is completing this authorization, 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: BlueChoice HealthPlan  
Attn: Sandy Wright, Compliance Manager (AX-400)  
P.O. Box 6170  
Columbia, SC 29260-6170  
(803) 382-5472 (phone number)  
(803) 735-9675 (fax number)**

*\*This authorization does not apply to alcohol or substance abuse information unless specifically authorized in Section 2.*