BlueChoice® HealthPlan
South Carolina
An independent licensee of the Blue Cross and Blue Shield Association

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

PLEASE RETURN THIS FORM TO: BlueChoice HealthPlan of South Carolina, Inc., Attn: Privacy Officer (AX-400), P.O. Box 6170, Columbia, SC 29260-6170. Fax number 803-714-6443

SECTION 1. MEMBER INFORMATION. (INDIVIDUAL WHOSE INFORMATION MAY BE DISCLOSED)

Name:_____ Date of Birth:_____ Telephone:_____

Address:_____

Primary Member's ID Number or Social Security Number:_____

Spouse's Name: (if included in authorization)_____ Date of Birth:_____

Dependent's Name, ***Age 16 or Older*****:** (if included in authorization)

_____

_____

Dependent's Name, ***Under Age 16*****:** (if included in authorization)

_____

_____

SECTION 2. AUTHORIZED INDIVIDUAL/ENTITY. (PERSON OR ORGANIZATION RECEIVING YOUR INFORMATION)

I authorize BlueChoice HealthPlan to disclose my PHI to:

Name:_____ Relationship:_____

Address:_____ Telephone:_____

Name:_____ Relationship:_____

Address:_____ Telephone:_____

SECTION 3. DESCRIPTION OF INFORMATION TO BE RELEASED. (TYPE OF INFORMATION THAT WILL BE USED OR DISCLOSED.)

Please check **only one**:

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

_____ Also include any alcohol and substance abuse records, if applicable. (Indicate by initialing)
This authorization will not apply to alcohol or substance abuse information unless specifically authorized.

☐ I authorize BlueChoice HealthPlan to disclose **ONLY** the following PHI:_____

This authorization is made at my request or for this purpose(s):_____

SECTION 4. EXPIRATION AND REVOCATION. (WHEN THIS AUTHORIZATION WILL END)

Expiration: This authorization will expire (Chose one):

☐ On _____/_____/_____. ☐ 12 months after termination of my coverage with BlueChoice HealthPlan.

Revocation: I understand that I may revoke this authorization 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 BlueChoice HealthPlan on this authorization before my written notice of revocation was received.

SECTION 5. SIGNATURE.

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 the Authorized Individual/Entity may not be subject to federal/state privacy laws and they 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 legal Personal Representative is completing this authorization, the Personal Representative must sign below and attach legal documentation that establishes his or her authority to act on the individual's behalf.

Personal Representative's Printed Name/Signature:_____

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