VOLUNTARY AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO A THIRD PARTY

Please complete this form and send it to the following address:

Group & Individual Privacy Official (AX-E05)
BlueCross® BlueShield® of South Carolina
I-20 at Alpine Road
Columbia, SC 29219
Fax: (803) 264-0174

Section 1: Authorization – I authorize the following people or entities to receive, use or disclose my protected health information as described in Sections 2 and 3 below. Please indicate only those who you wish to have access to your protected health information in order to assist you.

☐ Spouse – Name:_____
Address:_____
Phone Number:_____

☐ Agent/Agency – Name:_____
Address:_____
Phone Number:_____
Agency Number:_____

☐ Benefit Coordinator of Insurance Coverage:
Name:_____
Address:_____
Phone Number:_____

☐ Other – Name:_____
Address:_____
Phone Number:_____
Relationship:_____

I understand this agreement is voluntary and BlueCross BlueShield of South Carolina will not condition eligibility for insurance based on whether or not I sign this form. I understand that the above named may further disclose my information, and federal or state privacy laws may not protect it (e.g., in cases of disaster relief, public health reports or investigations or other situations permitted by law).

Section 2: Purpose and Scope of Authority – The purpose of this authorization is to allow the above named the ability access to my protected health information as follows:

☐ I authorize BlueCross BlueShield of South Carolina to disclose my protected health information concerning all my claims information (except for any psychotherapy notes) or claims payments while I am covered under BlueCross.

Please list any limitations on the above:_____

AND/OR

☐ I authorize BlueCross BlueShield of South Carolina to disclose my protected health information (except for any psychotherapy notes) as follows **(please be as specific as possible)**:_____
_____

Section 3: Options for Disclosures – I authorize the disclosure of my protected health information to the above named by the telephone or by sending copies of all documents concerning eligibility by U.S. mail, by fax, hand delivery or by an electronic transmission.

Section 4: Expiration and Revocation – **Expiration**: This authorization will expire: 1) upon the effective date of my termination of coverage with BlueCross BlueShield of South Carolina policy; 2) when the above named is no longer my agent/agency; or 3) upon my written revocation, whichever occurs first. **Revocation**: I understand that I may revoke this authorization at any time by giving written notice of my revocation to address listed above. I understand that revocation of this authorization will not affect any action BlueCross took in reliance on this authorization before BlueCross received my notice of revocation.

Section 5: Person(s) Authorizing and Signature – I, the undersigned, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction. I understand that, by signing this form, I am confirming my authorization, the scope of authority, the means by which disclosures may be made, the expiration of this authorization and the option of revoking of this authorization. All individuals whose names are included in Section 5, may have their Protected Health Information disclosed to any person(s) or entities listed in Section 1.

Print Policyholder's or Covered Employee's Name and Address:_____
_____Telephone Number:_____

The ID Number or Social Security Number claims will be filed under: ☐☐☐-☐☐-☐☐☐☐☐☐

List **Dependents Under Age 18** to be included in this Authorization for Disclosure of their Protected Health Information to the person(s)/entities named in Section 1:

Name:_____D.O.B.___/___/___Name:_____D.O.B.___/___/___

Name:_____D.O.B.___/___/___Name:_____D.O.B.___/___/___

SIGNATURE:_____Print Name:_____Date: ___/___/___

Spouse's Signature:_____Print Name:_____Date:___/___/___
(If applicable)

Dependent 18 or older Signature:_____Print Name:_____Date:___/___/___
(If applicable)

Please Note: The Applicant/Member may not sign this authorization for a Spouse or Dependents age 18 or over.

You should keep a signed copy of this authorization form for your records; however, a copy of this signed authorization will be provided upon your request.

Service – Track104 (Rev.1/06) Order # 12214M