



BlueCross BlueShield of South Carolina

An independent licensee of
Blue Cross and Blue Shield Association

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO A THIRD PARTY

1. **Authorization.** I authorize BlueCross BlueShield of South Carolina to disclose my protected health information to the following individual or entity as described in Section 2 below.

Name: _____

Address: _____

Telephone: _____ Relationship: _____

2. **Scope of Authority.** I authorize the above named to have access to my protected health information as follows (**check only one**):

I authorize BlueCross BlueShield of South Carolina to disclose **any** protected health information (except psychotherapy notes) that the above-named individual/entity may request. My protected health information may include: information pertaining to chronic diseases, behavioral health conditions, communicable diseases including HIV or AIDS, and/or genetic information.
_____ I also want to include my alcohol and substance abuse records, if applicable.* (Please initial on the line.)

I authorize BlueCross BlueShield of South Carolina to disclose **ONLY** the following protected health information to the above-named individual/entity:

3. **Purpose.** This authorization is made:

- At my request.
- For the following purpose(s): _____

4. **Expiration and Revocation.**

I understand that I may revoke this authorization at any time by providing written notice of my revocation to BlueCross BlueShield of South Carolina at the address listed below. I understand that revocation of this authorization will **not** affect any action taken by BlueCross BlueShield of South Carolina in reliance on 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 BlueCross BlueShield of South Carolina, unless earlier revoked by me or my personal representative.

5. **Signature.** (A separate form must be completed by any individual age 18 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 BlueCross BlueShield of South Carolina 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 this authorization is being completed by a personal representative on behalf of the individual, please complete the following and attach legal documentation establishing your personal representative authority:

Personal Representative's Name: _____ Signature: _____

Please return this form to: BlueCross BlueShield of South Carolina
Attn: Kara Kennedy, Subpoena Coordinator
I-20 @ Alpine Rd., AA-270
Columbia, SC 29219
(803) 264-3305 (phone)
(803) 736-2713 (fax)

*This authorization will not apply to alcohol or substance abuse information unless specifically requested under Section 2.