GROUP & INDIVIDUAL MARKETING

FYI

South Carolina

June 17, 2013

No Form. No Way.

If you or anyone on your staff needs protected health information about a client, you must have a signed Authorization to Disclose Protected Health Information to a Third Party form.

This is a legal requirement of the Health Insurance Portability and Accountability Act (HIPAA).

While certain exceptions may have been made in the past, we are now enforcing this requirement in all cases. No kidding.

We have attached the authorization form as a courtesy.

Please contact your marketing representative with any additional questions.

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 to a Third Party

RETURN THIS FORM TO:
BlueCross BlueShield of South Carolina Group & Individual Privacy Official, I-20 at Alpine Road (AX-E05), Columbia, SC 29219-0001 Fax Number: 803-264-0174

SECTION A – MEMBER INFORMATION (INDIVIDUAL WHOSE INFORMATION WILL BE RELEASED):

Name: (Last, First, Middle Initial)	Date of Birth: (DOB) / /	Telephone Number: (Including area code)
Address: (Including Zip)		
Primary Member's ID Number (as shown on the Primary Member's identification card) or Social Security Number:		
Spouse's Name* / DOB: (if included in authorization)		
Dependent's Name* age 16 or older / DOB: (if included in this authorization) _____ _____	Dependents under age 16 / DOB: (if included in authorization) _____ _____	

*Spouse and/or dependent age 16 or older must sign this authorization agreeing to the release of protected health information.

SECTION B – AUTHORIZED PERSON (PERSON OR ORGANIZATION RECEIVING YOUR INFORMATION):

I authorize BlueCross BlueShield of South Carolina to disclose protected health information to:

Name:	Relationship:
Address:	Telephone:
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).

1. Please 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. 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 abuse records, if applicable*. (*Indicate by Initialing*)

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

_____

2. This authorization is made: ☐ At my request ☐ For the following purpose(s):_____

*This authorization will not apply to alcohol or substance abuse information unless specifically authorized.

SECTION D – EXPIRATION AND REVOCATION: (WHEN THIS AUTHORIZATION WILL END).

Expiration: This authorization will expire on ____/____/_____ or 12 months after termination of coverage with BlueCross BlueShield of South Carolina or upon my written revocation, whichever occurs first.

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 voluntarily 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 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:_____

Spouse's 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 as the individual's personal representative.

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