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 (AF-600)
BlueCross BlueShield of South Carolina
I-20 at Alpine Road
Columbia, SC 29219
Facsimile: (803) 264-0174

Section 1: Authorization

I authorize: Name:_____ Telephone Number:_____

Address: _____

Relationship: ☐ Spouse ☐ Agent/Agency ☐ Group Leader of Insurance Coverage ☐ Other – explain:_____

to receive, use or disclose claim information as described in Sections 2 and 3 below. 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 to discuss with BlueCross and me my Protected Health Information as indicated below.

I authorize BlueCross BlueShield of South Carolina to disclose my protected health information concerning my claims information (except for any psychotherapy notes) or claims payments:

☐ All claims while I am covered under BlueCross
☐ Claim(s) Dated:_____
☐ Claims from the following provider(s):_____
☐ Claims with dates of service from:_____ to _____

Please list any limitations on the above:_____

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 facsimile, 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 Blue Shield 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: 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.

Print Name:_____

Policyholder's or Covered Employee's Name:_____

Address:_____

Telephone Number: _____

Relationship to Policyholder/Covered Employee_____

Policyholder's or Covered Employee's Social Security Number: _____

Signature:_____Date: _____

You are entitled to a copy of this Authorization Form

Service – Track102 Order # 12214M