

## AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO A THIRD PARTY

Nama	Date of Birth:	Talanhana Numbari
	Date of Birth:	
-		
	ze BlueCross BlueShield of South Carolina to disclo al/entity in the manner described in Section 3 below.	se the above listed member's protected health information
Name:		
Mailing Address:		
Telephone:	Relationship:	
	norize the disclosure of my protected health informat k only one)	ion to the above-named individual/entity as follows:
request. If applicable,		ychotherapy notes) that the above-named individual/entity may o chronic diseases, behavioral health conditions, communicable
Also incl	lude any alcohol and substance abuse records, if applic	able. * (indicate by initialing)
*This authorization will no	at apply to alcohol or substance abuse information unle	ss specifically authorized above.
	to disclose ONLY the following protected health inform	
I dudionze Bidecross	to disclose <u>office</u> the following protected ficulti fillori	nation to the above named marvidad/entry.
Purpose. This authorizat	ion is made:	
At my request.		
At my request.	ion is made:	
At my request.	ose(s):	
<ul><li>☐ At my request.</li><li>☐ For the following purp</li><li>Expiration and Revocation</li></ul>	ose(s):	ter termination of my coverage under BlueCross, whichever
☐ At my request. ☐ For the following purp  Expiration and Revocation  Expiration: This authoriz occurs first.	on. ation will expire on/ or 12 months af	
☐ At my request. ☐ For the following purp  Expiration and Revocation  Expiration: This authoriz occurs first.  Revocation: I understand to	one.  ation will expire on/ or 12 months after that I may revoke this authorization at any time by sendithat revocation of this authorization will not affect any	iter termination of my coverage under BlueCross, whichever
☐ At my request. ☐ For the following purp  Expiration and Revocation  Expiration: This authorizoccurs first.  Revocation: I understand to Please note: I understand before my written notice of	ation will expire on/ or 12 months after that I may revoke this authorization at any time by sendithat revocation of this authorization will <i>not</i> affect any frevocation was received.	ter termination of my coverage under BlueCross, whichever ng written notice of my revocation to the address shown below.
☐ At my request. ☐ For the following purp  Expiration and Revocation  Expiration: This authorize occurs first.  Revocation: I understand to Please note: I understand before my written notice of Signature. (Any individual I am making this authoriza BlueCross will not condition	ation will expire on/ or 12 months aften I may revoke this authorization at any time by sending that revocation of this authorization will <i>not</i> affect any for revocation was received.  In all age 16 or over who wishes to grant authorization must tion voluntarily and have had full opportunity to read a con my enrollment in a health plan, eligibility for benefit ormation disclosed pursuant to this authorization may be	ther termination of my coverage under BlueCross, whichever and written notice of my revocation to the address shown below. action taken by BlueCross in reliance on this authorization
At my request.  For the following purp  Expiration and Revocation  Expiration: This authorize occurs first.  Revocation: I understand to Please note: I understand before my written notice of Signature. (Any individual I am making this authoriza BlueCross will not condition further understand that inforprotected by federal or state	ation will expire on/ or 12 months aften I may revoke this authorization at any time by sending that revocation of this authorization will not affect any for revocation was received.  Leal age 16 or over who wishes to grant authorization must tion voluntarily and have had full opportunity to read a confirmation disclosed pursuant to this authorization may be privacy laws.	ther termination of my coverage under BlueCross, whichever and written notice of my revocation to the address shown below. action taken by BlueCross in reliance on this authorization ust complete their own individual authorization form.) and consider the contents of this authorization. I understand that its, or payment of claims upon my signing this authorization. I
At my request.  For the following purp  Expiration and Revocation  Expiration: This authorize occurs first.  Revocation: I understand to Please note: I understand before my written notice of Signature. (Any individual I am making this authoriza BlueCross will not condition further understand that information protected by federal or state Signature:	ation will expire on/ or 12 months aften I may revoke this authorization at any time by sending that revocation of this authorization will not affect any for revocation was received.  It all age 16 or over who wishes to grant authorization must tion voluntarily and have had full opportunity to read a confirm may be on my enrollment in a health plan, eligibility for benefit ormation disclosed pursuant to this authorization may be privacy laws.	refer termination of my coverage under BlueCross, whichever and written notice of my revocation to the address shown below. action taken by BlueCross in reliance on this authorization sust complete their own individual authorization form.) and consider the contents of this authorization. I understand that its, or payment of claims upon my signing this authorization. I be subject to re-disclosure by the recipient and may no longer be

If this authorization is completed by a personal representative on behalf of the individual, the personal representative must **attach legal documentation** establishing authority to act as the individual's personal representative.

Please return this form to: Attn: Vinnetta Osborne, HIPAA Privacy Official (AX-G50)

P.O. Box 100300

Columbia, South Carolina 29202 (803) 736-8983 (fax number)

If you have any questions, please call Customer Service at the number on the back of your ID card.