



Voluntary Authorization to Disclose Protected Health Information to a Third Party

RETURN THIS FORM TO:

BlueCross BlueShield of South Carolina, Group and 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: Telephone Number: (including area code) Address: (Including Zip Code) Member's ID Number (as shown on the Member's identification card) or Social Security Number: Spouse's Name* (if included in this authorization): Date of Birth: Dependent's Name* age 16 or older to be included in this authorization: Date of Birth: *That person must sign this authorization below agreeing to the release of his or her protected health information.

List Dependents under age 16 to be included in this authorization:

Name: Date of Birth: Name: Date of Birth:

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

I authorize BlueCross BlueShield of South Carolina to disclose protected health information on the above individuals to:

Name: Address: Phone Number: Relationship to Member: Agent/Agency Name: David A. Crotts & Associates Address: 422 Montague Ave. - Suite #7, Greenwood, SC 29649 Phone Number: 800-803-7873 or 864-223-8788 Agency/Agent Number: 150

SECTION C – DESCRIPTION OF INFORMATION TO BE RELEASED: (TYPE OF INFORMATION THAT WILL BE USED OR DISCLOSED).

1. Please check only one: [X] I authorize BlueCross BlueShield of South Carolina to disclose any protected health information (except psychotherapy notes) that the above-name individual/entity may request. [] I authorize BlueCross BlueShield of South Carolina to disclose ONLY the following protected health information to the above-named individual/entity. 2. This authorization is made: [] At my request [] For the following purpose(s):

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

Expiration: This authorization will expire 12 months after termination of coverage under BlueCross BlueShield of South Carolina policy 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. Please note: Your revocation will not affect any action taken before receipt of your notice of revocation.

SECTION E – SIGNATURE*/DATE

I understand the nature of this release. I also understand that if the person or organization I authorize to receive the information described in Section C is not subject to federal health information privacy laws, that person or entity may further disclose the protected health information and federal privacy laws may no longer protect it. I understand that authorizing the use and disclosure of my information is not a condition of this health plan, eligibility for benefits or payment of claims.

Signature: Spouse's Signature: Dependent age 16 or older Signature: Date: SIGN HERE

*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, a copy will be provided upon your request.