BlueChoice® HealthPlan
South Carolina
An independent licensee of the Blue Cross and Blue Shield Association

Authorization to Disclose Protected Health Information (PHI) to a Third Party

PLEASE RETURN THIS FORM TO: BlueChoice HealthPlan of South Carolina, Inc., Attn: Privacy Official (AX-400), P.O. Box 6170, Columbia, SC 29260-6170. Fax number 803-714-6443

SECTION 1. MEMBER INFORMATION. (INDIVIDUAL WHOSE INFORMATION MAY BE DISCLOSED)

Name:_____ Date of Birth:_____ Telephone:_____

Address:_____

Primary Member's ID Number or Social Security Number:_____

Spouse's Name: (if included in authorization)_____ Date of Birth:_____

Dependent's Name, ***Age 16 or Older*****:** (if included in authorization)

_____

_____

Dependent's Name, ***Under Age 16*****:** (if included in authorization)

_____

_____

SECTION 2. AUTHORIZED INDIVIDUAL/ENTITY. (PERSON OR ORGANIZATION RECEIVING YOUR INFORMATION)

I authorize BlueChoice HealthPlan to disclose my PHI to:

Name:_____ Relationship:_____

Address:_____ Telephone:_____

Name:_____ Relationship:_____

Address:_____ Telephone:_____

SECTION 3. DESCRIPTION OF INFORMATION TO BE RELEASED. (TYPE OF INFORMATION THAT WILL BE USED OR DISCLOSED.)

Please check **only one**:

☐ I authorize BlueChoice HealthPlan to disclose **any** of my PHI (except psychotherapy notes) that the above-named individual/entity may request. I understand the information may include information pertaining to chronic diseases, behavioral health conditions and communicable diseases, including HIV or AIDS and/or genetic information.

_____ Also include any alcohol and substance abuse records, if applicable. (Indicate by initialing)
This authorization will not apply to alcohol or substance abuse information unless specifically authorized.

☐ I authorize BlueChoice HealthPlan to disclose **ONLY** the following PHI:_____

This authorization is made at my request or for this purpose(s):_____

SECTION 4. EXPIRATION AND REVOCATION. (WHEN THIS AUTHORIZATION WILL END)

Expiration: This authorization will expire (Chose one):

☐ On _____/_____/_____. ☐ 12 months after termination of my coverage with BlueChoice HealthPlan.

Revocation: I understand that I may revoke this authorization 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 BlueChoice HealthPlan on this authorization before my written notice of revocation was received.

SECTION 5. SIGNATURE.

I am making this authorization voluntarily and have had full opportunity to read and consider the contents of this authorization. I understand that BlueChoice HealthPlan will not condition my enrollment in a health plan, eligibility for benefits or payment of claims upon my signing this authorization. I further understand the Authorized Individual/Entity may not be subject to federal/state privacy laws and they may further release my PHI.

Signature:_____ Date:_____

Spouse's Signature:_____ Date:_____

Dependent Age 16 or Older Signature:_____ Date:_____

Dependent Age 16 or Older Signature:_____ Date:_____

If the individual's legal Personal Representative is completing this authorization, the Personal Representative must sign below and attach legal documentation that establishes his or her authority to act on the individual's behalf.

Personal Representative's Printed Name/Signature:_____

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

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice (TDD: 711).

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance by emailing contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険 についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

Ni da doodago t'áá háída bíká'aná nílwo'ígíí díí Béeso Ách'ą́ąh naa'nilígi háá'ída yí na' ídíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'íshíį́ bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'į' ha desdzih nínízingo, kojį' béésh bee hólne' 1-844-516-6328. (Navajo)