Voluntary Authorization to Disclose Protected Health Information to a Third Party

RETURN THIS FORM TO:
TCC Benefits Administrator, PO Box 63477, North Charleston, SC 29419 Fax Number 803-264-9285

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: _____	Name: _____
Date of Birth: ____/____/____	Date of Birth: ____/____/____

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

I authorize TCC Benefits Administrator to disclose protected health information on the above individuals to:

Name: _____	Agent/Agency Name: _____
Address:	Address:
Phone Number: _____	Phone Number: _____
Relationship to Member: _____	Agency/Agent Number: _____

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

1. Please check only one:

☐ I authorize TCC Benefits Administrators to disclose any protected health information (except psychotherapy notes) that the above-name 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 TCC Benefits Administrator 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 TCC Benefits Administrator 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: _____ 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, a copy will be provided upon your request.