FirstChoice
by Select Health of South Carolina
Your Hometown Health Plan

Healthy Connections

Authorization To Use and/or Disclose Protected Health Information

1. Member name _____

Member ID number _____ **Date of birth** _____

2. Description of information to be used and/or disclosed:

- Examples: "prescription medicine history" or "skilled nursing care approved by the plan"

_____

_____

3. Who is authorized to use and/or disclose the information?

- Tell who is authorized to use and/or disclose your health information.
- Examples: "First Choice" or "Dr. Jones"

_____

_____

4. Who is authorized to get the information?

- Name who is authorized to get the above information.
- Example: "Martha Smith, mother"

_____

_____

5. Reason the information will be used and/or disclosed:

- If the member has asked to share his or her protected health information, fill in below **"At the request of the individual."**
- If the reason the information will be used includes **"Marketing,"** please indicate if Select Health ☐ **will** or ☐ **will not** receive payment as a result of using and/or disclosing this information. This does not include payment for any services provided to you.

_____

_____

6. Expiration date or event, if any (if none, mark as N/A):

_____

_____

MEMBER NOTICE PROVISIONS

You can cancel this authorization at any time. To cancel, send a written statement to the Select Health Privacy Officer, P.O. Box 40849, Charleston, SC 29423. The statement must identify this authorization by referring to the date it was signed (below). The statement must include the date the authorization ends.

If you cancel this authorization, we may still use and disclose the information for the purposes listed, if we have already acted. Also, if this authorization is to allow disclosure of information to an insurance company for you to get insurance coverage, the insurance company may still have the right to use the information to contest a claim or your coverage.

You may refuse to sign this authorization. You do not need to sign this to get health care services EXCEPT in these cases:

- If the only purpose for providing you with a service is to get health information to disclose to someone else, then you must authorize that disclosure to get the service.
- If the services are related to research, you may need to authorize the use and/or disclosure of your health information. This applies only to health information related to the research services. The use and/or disclosure of your information will be limited to what is necessary for the research. If you do not authorize the use and/or disclosure of your information for the research, you may not be able to get the services.

You do not have to sign this authorization to get payment, enroll in First Choice or to be eligible for benefits. Under federal law, you do not have to authorize us to get the private notes from counseling sessions that are kept by a mental health professional as a condition of payment, enrollment in a heath plan or eligibility for benefits.

A person or organization that gets your information because of this authorization may have the legal right to disclose it to other people or organizations without your knowledge or consent.

Signature _____ Date _____

If this authorization is signed by someone who is not the member listed on the previous page, provide a description of the signer's authority to act for the member.

_____

You will be provided with one copy of this form.

Definitions:

Authorization: consent, permission

Disclose: make known, share

Protected Health Information (PHI): data collected by a health care professional to identify an individual and determine appropriate care.