Authorization for Sharing Health Information

[Please print]

FirstChoice℠ by Select Health of South Carolina
Your Hometown Health Plan

Healthy Connections

This form is used to share your protected health information ("PHI") where required by federal and state privacy laws. Your authorization allows First Choice℠ by Select Health of South Carolina to share your PHI with the person(s) or organization(s) that you choose. You can also choose to allow the person(s) or organization(s) to share your PHI with First Choice by Select Health of South Carolina. You can cancel this authorization at any time by submitting a request to First Choice by Select Health of South Carolina. Contact Member Services at **1-888-276-2020 (TTY 711)** for further instructions.

Part A. Member Information: (individual whose PHI will be shared)

Member First Name:		Middle Initial:
Last Name:	Member ID (see ID card):	
Member Street Address:		
City:	State:	ZIP code:
Member Date of Birth:	Daytime Phone Number (with area code):	

Part B. Recipient: (person or organization that will receive your PHI)

The following individual or organization has the right to receive my PHI:

Do you want the following individual or organization to also share your PHI with us? ☐ Yes ☐ No

First Name:	Last Name:	
Organization Name (if applicable)		
Address:		
City:	State:	ZIP code:
Phone Number (with area code):		
Relationship to Member in Part A:		

Part C. Description of the PHI to be Shared:

Tell us what types of PHI can be shared. You can check as many boxes as you want. At least one box must be selected.

☐ **Entire record.** All PHI related to the provision of and payment for my health care benefits and services. Federal law requires a separate authorization to share psychotherapy notes.

☐ **Special records. <u>Some laws require you to give specific permission to share certain PHI. Please check the boxes below for PHI that is OK to share</u>.** By checking these boxes, you give permission for all your records containing that type of PHI to be shared. If you only want to authorize sharing of a subset of records, such as records about only one diagnosis, fill out the "Only limited information" section below.

☐ Genetic information
☐ HIV/AIDS
☐ Substance or alcohol use
☐ Mental/behavioral health (including inpatient treatment)
☐ Sexually transmitted disease
☐ Abortion and family planning
☐ Communicable diseases
☐ Information you have asked us to treat confidentially

☐ **Only limited information.** In the box below, describe the PHI you want shared. Examples:

- The claim related to my service on [date].
- Appeal information related to my claim on [date].

Please describe the information you want shared:

Part D. Purpose of this Authorization

This authorization is valid for sharing of PHI for the following purposes. (Please check one or both boxes.)

☐ To help diagnose, treat, manage and/or pay for my health needs.

OR

☐ For the following reason:

This authorization shall be invalid if used for any purpose other than the purpose(s) stated above.

Part E. Expiration Date of this Authorization

This authorization will expire. (Please check one box.)

☐ I want the authorization to expire one (1) year after my coverage with First Choice by Select Health of South Carolina ends. (See information below)*

OR

☐ Upon the following date, event or condition*:

* First Choice by Select Health of South Carolina must be notified of the event/condition to cancel this authorization. In North Carolina and New Jersey, this authorization automatically expires one year after the date it was signed, unless you choose an earlier date. In New Hampshire, the authorization automatically expires two years after the date it was signed, unless you choose an earlier date. In Louisiana, if you are requesting the sharing of genetic information, the authorization expires sixty days after the date it was signed, unless you choose an earlier date. In the District of Columbia, if you are requesting the sharing of mental health information, the authorization automatically expires one year after the date it was signed, unless you choose an earlier date.

Part F. Approval: (You OR your Personal Representative must sign and date this form in order for it to be complete.)

I understand that this authorization for sharing my PHI is voluntary and is not a condition of enrollment in First Choice by Select Health of South Carolina, eligibility for benefits, or payment of claims. I understand that I may cancel this authorization at any time by submitting a request to First Choice by Select Health of South Carolina, and that canceling this authorization will not affect any action taken pursuant to the authorization prior to my request to cancel. I also understand that if I cancel this authorization, I should separately notify the individual(s) or organization(s) listed in Part B above if I wish for those individual(s) or organization(s) to no longer share my PHI. I also understand that if the person or organization I authorize to receive my PHI described above is not subject to federal or state health information privacy laws, they may further share my PHI and it may no longer be protected by federal or state privacy laws. I also understand that I or my personal representative have a right to receive a copy of this form and to review my PHI that may be shared because of this authorization.

Member Signature: By signing below, I authorize the sharing of my PHI as described above.	
Signature of Member:	Date:

Personal Representative Information: By signing below, I authorize the sharing of PHI of the member as described above. (A Personal Representative is a person who has the legal authority to act on behalf of an individual, such as a parent of a minor. A copy of a Power of Attorney or other legal document must be on file at First Choice by Select Health of South Carolina or submitted with this form.)	
Printed Name of Personal Representative:	
Address of Representative:	
Description of Personal Representative's Authority:	
Signature of Personal Representative:	
Date:	Phone Number:

Return the Completed Form to: Consent Processing Center, P.O. Box 7092, London, KY 40742-7092
Fax Number: 1-833-214-2242 (Toll Free)

Addendum to Authorization for Disclosure of Health Information

Verbal consent

We, the undersigned, attest that the member identified in Section A above is **physically unable** to sign this authorization. Verbal consent does not replace the need for documentation showing that another person is the member's personal representative, and cannot replace this documentation simply because it is inconvenient for the member to sign.

Reason:

The signatures below indicate:

- The information on this form was communicated to the member.
- The member indicated their understanding of the information in this authorization.
- The member freely gave their consent.

Method of communication to member:

☐ Phone

☐ In person

☐ Other (specify):

Witness printed name:	Witness printed name:
Witness signature:	Witness signature:
Date: / /	Date: / /

If your primary language is not English, language services are available to you, free of charge. Call **1-888-276-2020** (**TTY 1-888-765-9586**).

Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-888-276-2020** (**TTY 1-888-765-9586**).

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www.selecthealthofsc.com