AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO A THIRD PARTY

1. Authorization. I authorize TCC Benefits Administrator to disclose my protected health information to the following individual/entity in the manner described in Section 2 below.

Name: _____

Address: _____

Telephone: _____ Relationship: _____

2. Scope of Authority. I authorize the disclosure of my protected health information to the above-named individual/entity as follows: (check only one)

‰ I authorize **TCC** to disclose any protected health information (except psychotherapy notes) that the above-named 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** to disclose ONLY the following protected health information to the above-named individual/entity:

_____

_____

3. Purpose. This authorization is made:

‰ At my request.

‰ For the following purpose(s): _____

4. Expiration and Revocation.

I understand that I may revoke this authorization at any time by providing written notice of my revocation to **TCC** at the address listed below. I understand that revocation of this authorization will *not* affect any action taken by **TCC** in reliance on this authorization before my written notice of revocation was received.

I understand that this authorization will expire 12 months after termination of my coverage with [**TCC**], unless earlier revoked by me or my personal representative.

5. Signature. (A separate form must be completed by any individual age 18 or over who wishes to grant authorization.)

I am making this authorization voluntarily and have had full opportunity to read and consider the contents of this authorization. I understand that **TCC** will not condition my enrollment in a health plan, eligibility for benefits, or payment of claims upon my signing this authorization. I further understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Signature: _____ Date: _____

Print Name: _____ Member ID Number: _____

If this authorization is completed by a personal representative on behalf of the individual, the personal representative must complete the following and attach legal documentation establishing authority to act as the individual's personal representative.

Personal Representative's Name: _____ Signature: _____

Please return this form to: TCC Benefits Administrator
P.O. Box 22557
Charleston, SC 29413
843-722-2115 Phone Number
843-722-2866 Fax Number

*This authorization will not apply to alcohol or substance abuse information unless specifically authorized under Section 2.