VOLUNTARY AUTHORIZATION for Full Use and Disclosure of Health Information

I authorize Carolina Care Plan®, Inc. (CCP℠) to use and disclose the following Protected Health Information (PHI) from the records of the following CCP member. I understand that this authorization is voluntary, and I may choose not to sign it.

PLEASE PRINT

CCP Member Information

Name: _____ Address:_____

9-digit CCP Member #: _____-_____-_____ _____

Date of Birth: _____/_____/_____ _____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Level of Authorization

☐ CCP may disclose Protected Health Information to the person indicated below to answer his/her questions about this member's claims status, eligibility, benefit coverage and member-specific clinical information.

☐ I do not wish the person below to receive the following information:

_____

Persons authorized to receive this information: (please attach list of names if more than one person)

Name: _____ Address: _____

Company: _____ _____

Relationship: _____ _____

Terms of This Authorization

This authorization will expire one (1) year after the date of my signature below. I may instruct Carolina Care Plan, Inc. to revoke this authorization sooner if I do so in writing. Revoking this authorization will apply only to CCP's actions after the date CCP receives my written request. I may contact the CCP Customer Service staff to begin this process.

I understand that CCP will not condition treatment, payment, enrollment or eligibility on whether I sign this authorization.

I may inspect or request a copy of my Protected Health Information. I understand that CCP may charge a fee to reproduce PHI records. CCP must receive payment of this fee before it will release copies of the records.

I will not hold CCP legally responsible or liable for disclosing information as described here. I understand that, once CCP discloses information to the person I am authorizing, federal privacy regulations may no longer protect it. I may seek assurances from the persons/entities authorized to receive this information that they will not redisclose this information without my authorization or permission.

_____ _____/_____/_____

Signature of Member Date

_____ _____ _____/_____/_____

Or, Signature of Personal Representative Relationship Date

Please return to: Carolina Care Plan, Inc., 201 Executive Center Drive, Columbia, SC 29210
(803) 750-7400