AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Please complete this form and send it to the following:

TCC Benefits Administrator
P.O. Box 22557
Charleston, SC 29413

Fax: (803) 264-7134

Section 1: Authorization – I authorize my past or present treating physicians/hospitals/clinics, licensed medical providers, pharmacies, and/or pharmacy-related service organizations to disclose to TCC Benefits Administrator ("TCC"), or its designated agent, my protected personal health information concerning symptoms or conditions for which I may have been treated or given advice for, but does not include psychotherapy notes, in the 10 years prior to my signing this authorization. I understand this authorization is voluntary. However, TCC reserves the right to deny eligibility for benefits if I refuse to sign this form. I 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

Section 2: Purpose – The purpose of this authorization is for TCC to obtain copies of documents related to my medical history in order to determine eligibility for benefits after enrollment, and the requested use or disclosure does not include psychotherapy notes.

Section 3: Options for Disclosures – Disclosure may occur by sending copies of documents concerning my medical history in the 10 years prior to my signing this form by U.S. mail, by fax, hand delivery or by a secure electronic transmission.

Section 4: Expiration and Revocation – **Expiration**: This authorization will expire: 1) 12 months after my signature date below; or 2) upon cancellation or rescission of my policy; or 3) upon my written revocation, whichever occurs first. **Revocation**: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the address listed above. TCC will condition my eligibility for benefits based on whether or not I sign this form. I understand that revocation of this authorization will not affect any action TCC took in reliance on this authorization before TCC received my notice of revocation.

Section 5: Signature – I, the undersigned, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction.

Print Member's Name: _____

Member's ID No.: _____ Member's Date of Birth: _____

Member's Signature: _____ Date: _____

Please Note: If this authorization is for a Dependent age 16 or over, that dependent must sign below.

Print Dependent's Name: _____

Member's ID No.: _____ Dependent's Date of Birth: _____

Dependent's Signature: _____ Date: _____
(Age 16 or Over)

You should keep a signed copy of this authorization for your records; however, a copy will be provided upon your request.