Companion
BENEFIT ALTERNATIVES

Phone: 800-868-1032
Fax: 803-714-6456
www.CompanionBenefitAlternatives.com

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO A THIRD PARTY

1. Member Information. Individual whose information may be disclosed.

Name: _____ Date of Birth: _____ Telephone Number: _____

Address: _____ Member ID#: _____

2. Authorization. I authorize Companion Benefit Alternatives, Inc. (CBA) to disclose the above listed member's protected health information to the following individual/entity in the manner described in Section 3 below.

Name: _____

Address: _____

Telephone: _____ Relationship: _____

3. 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 CBA 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*)

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

☐ I authorize CBA to disclose ONLY the following protected health information to the above-named individual/entity:

_____

_____

4. Purpose. This authorization is made:

☐ At my request.

☐ For the following purpose(s): _____

5. Expiration and Revocation.

Expiration: This authorization will expire (**choose one**):

☐ On _____/_____/_____.

☐ 12 months after termination of my coverage under my health plan.

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

6. Signature. (A separate form must be completed by any individual age 16 or older 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 CBA 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: _____

If this authorization is completed by a personal representative (PR) 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.

PR Name: _____ Signature: _____ Date: _____

Please return this form to: Companion Benefit Alternatives, Inc.
Attn: _____ (AX-315)
P.O. Box 100185
Columbia, SC 29202
Fax number: 803-714-6456

If you have any questions, please call CBA at 1-800-868-1032.

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