SOUTH CAROLINA MEDICAL ASSOCIATION VOLUNTARY EMPLOYEES' BENEFICIARY ASSOCIATION WELFARE BENEFIT PLAN AND TRUST

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____(*Individual's Name*), hereby authorize the use or disclosure of my health information as described in this authorization.

1. Specific person/organization authorized *to make* the disclosure of or use the health information:

2. Specific person/organization authorized *to receive and use* the health information and address to which health information should be sent if requesting a copy:

3. Specific and meaningful description of information to be used or disclosed:

   ☐ medical examination report and conclusions related to a fitness-for-work exam
   ☐ results of drug testing for employment-related purposes
   ☐ other (describe in detail)

4. Purpose of the request (if you do not wish to state a purpose, please state "at the request of the individual"):

5. This authorization will expire when:

   ☐ my participation in the South Carolina Medical Association Voluntary Employees' Beneficiary Association Welfare Benefit Plan and Trust terminates
   ☐ other (state a specific date or event):

   If no date is provided, this authorization will expire one year from the date it is signed.

6. I understand that:

   (a) I have the right to revoke this authorization at any time prior to its expiration date by giving written notification to the HIPAA Privacy Officer, SCMA Members' Insurance Trust, at 132 Westpark Boulevard, Columbia, SC 29210, or by fax to 731-4021 or email: MITinfo@scmedical.org. I understand that the revocation will not affect actions taken by any HIPAA-covered entity in reliance on this authorization before it knows about the revocation. A revocation also will not impact an authorization that was obtained as a condition of obtaining insurance coverage if another law gives the insurer the right to contest a claim or the policy itself.

   (b) I have a right to a signed copy of this authorization.

   (c) a HIPAA-covered entity may not condition treatment, payment, enrollment, or eligibility for benefits on obtaining an authorization, except (1) a covered health care provider may condition research-related treatment and may condition services when provided solely for the purpose of creating health information for disclosure to a third party, and (2) a health plan may condition enrollment or eligibility for benefits if the authorization is sought before enrollment and is for the purpose of determining eligibility, enrollment, underwriting risk or risk rating. I understand that if this authorization is intended for employment-related purposes, such as a return-to-work exam or drug testing, my initial and continued employment and position are subject to my agreement to this authorization, and any additional authorization the Physician Insurance Plan of Alabama requests.

   (d) after this information is disclosed to an entity that is not covered by HIPAA, the information has potential to be redisclosed by the recipient and to no longer be subject to the protections of HIPAA. However, other laws that impact how your health information is handled may apply to the recipient.

_____ _____

Signature of individual or individual's representative **Date**

Personal Representative Section

If a personal representative is signing this form, that representative warrants that he or she has authority to sign this form on the basis of: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Do not use to release information for treatment or payment, except when information is psychotherapy notes or certain research information.