SCMA Members' Insurance Trust
A subsidiary of the South Carolina Medical Association

P.O. Box 11188 • Columbia, SC 29211-1188
Phone: 803-798-6207 • 1-800-327-1021
Fax: 803-731-4021 • Email: MITinfo@scmedical.org
www.scmamit.com

SCMA MEMBERS' INSURANCE TRUST
AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Member Name_____

Date of Birth _____ ID Number_____

I hereby authorize the use and disclosure of individually identifiable health information related to me, which is called "protected health information" (PHI) under a federal health privacy law.

Specific person/organization (or class of persons) authorized to provide/release the information:
_____

_____

Specific person/organization (or class of persons) authorized to receive and use the information:
_____

_____

Specific description of the information (e.g. written, electronic and oral information related to eligibility for benefits, claim detail, reports, and other documents related to claims for benefits for an injury or illness.)
_____

_____

Reason the information will be used or disclosed (If the member initiates the authorization the statement "at the request of the individual" is sufficient):
_____

_____

- I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.
- I understand that I may revoke this authorization at any time by notifying SCMA/MIT in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by SCMA/MIT before receiving my revocation.
- I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.
- I understand that if the purpose listed above includes "marketing", SCMA/MIT will not receive payment as a result of using or disclosing this information. This does not include payment for any services provided to you.

This authorization expires one year from date signed.

Name of Member_____

Signature of member_____ Date Signed_____

SCMA Members' Insurance Trust
A subsidiary of the South Carolina Medical Association

P.O. Box 11188 • Columbia, SC 29211-1188
Phone: 803-798-6207 • 1-800-327-1021
Fax: 803-731-4021 • Email: MITinfo@scmedical.org
www.scmamit.com

NOTICE TO MEMBER

You may revoke this authorization at any time. To revoke this authorization, send a written statement to:

SCMA/MIT
P.O. Box 11188
Columbia, SC 29211

The statement must identify this authorization by referring to the date it was signed. The statement must include the date on which this authorization is no longer in force.

If you revoke this authorization, we may still use and disclose the information for the purposes listed on the authorization if we have already taken action in reliance on this authorization. Also, if this authorization is to permit disclosure of information to an insurance company, in order for you to obtain insurance coverage, the insurance company may still have the legal right to use the information to contest a claim or to contest your coverage.

You may refuse to sign this authorization. You do not need to sign this authorization to receive health care services EXCEPT in the following circumstances:

- **If the only purpose for providing you with a service is to obtain health information to disclose to someone else, then you must authorize that disclosure in order to receive the service.**
- **If the services are related to research, you may be required to authorize the use or disclosure of your health information for the research. This applies only to health information related to the research services. The use and disclosure of your information will be limited to what is necessary for the research. If you do not authorize the use and disclosure of your information for the research, you may not be eligible to receive the services.**

You do not have to sign this authorization to receive payment, to enroll in the SCMA/MIT health plan, or to be eligible for benefits, except:

- **If this authorization is sought for the purpose of determining your eligibility for benefits or enrollment, then you must authorize SCMA/MIT to obtain the necessary information or the benefits or enrollment may be denied.**
- **If this authorization is sought for the purpose of underwriting or risk rating determinations, then you must authorize SCMA/MIT to obtain the necessary information or benefits or enrollment may be denied.**
- **Under Federal law, you do not have to authorize us to receive the private notes from counseling sessions that are kept by a mental health professional as a condition of payment, enrollment in a health plan, or eligibility for benefits.**

A person or organization that receives your information because of this authorization may have the legal right to disclose this information to other people or organization without your knowledge or consent.

Signature_____

Date _____

If this authorization is signed by someone who is not the member listed at the top of this form, provide a description of the signer's authority to act for the member (e.g. "Power of Attorney")
_____

_____

The member will be provided one copy of this form.