Authorization to Disclose Protected Health Information (PHI)

Child and Foster Parent/Caregiver Information

The South Carolina Department of Social Services (SCDSS) is the custodian of the child named below. The Director of SCDSS, Lillian B. Koller, authorizes **First Choice by Select Health of South Carolina** to discuss and disclose Protected Health Information (PHI) of ___________________________, Medicaid ID __________________, a foster child in the custody of SCDSS who is enrolled in First Choice, to foster caregiver(s) identified by the SCDSS employee (Caseworker).

Foster Parent/Caregiver Information:

Name(s): ____

Address: ____

Telephone: ____

SCDSS Caseworker Authorization to Disclose PHI

The SCDSS employee (Caseworker) identified below has authority to execute this authorization on behalf of Ms. Koller and the SCDSS. The SCDSS is authorizing disclosure of PHI to ________________________________ (Foster Parent/Caregiver) for the purpose of provision, facilitation and coordination of health care. The SCDSS acknowledges that this authorization is voluntary.

SCDSS Employee (signature) ______________________ Date ______________

Print name ______________________ Title ______________________

Telephone ______________________ SCDSS Office ______________________

Notice of Revocation

The SCDSS hereby revokes the authorization granted above effective this date.

SCDSS Employee (signature) ______________________ Date ______________

Print name ______________________ Title ______________________

Telephone ______________________ SCDSS Office ______________________

Please fax this form to 1.888.963.7073.