Blue Cross Blue Shield Blue Care Network of Michigan

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Section A: Authorization
I authorize the use and disclosure of my protected health information (PHI) as described in Sections B and C below. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

NAME			DAYTIME PHONE NUMBER
KEITH ARP			
ADDRESS			
CITY	STATE	ZIP	CONTRACT NUMBER

Section B: PHI Use and Disclosure (NOTE: Use Form 7656 to authorize use and disclosure of psychotherapy notes.)
Describe in detail the PHI to be used and disclosed (providers, treatment dates, type of service, etc.):

☐ Check here if your authorization includes the disclosure of PHI regarding testing or treatment for AIDS, AIDS-related complex or HIV.

BCBSM, BCN and BCMI members - Please check if your authorization includes the disclosure of PHI regarding:

☐ **Substance abuse** (including alcoholism)

☐ **Mental Health Services** (excluding psychotherapy notes)

Section C: Authorized Use and Disclosures as described in Section B

NOTE: *If PHI is disclosed under your authorization to persons or organizations not subject to federal privacy laws, it may be re-disclosed and no longer protected.*

☒ I authorize BCBSM, BCN or BCMI (check one) to disclose my PHI to the following person(s) and entities:
METRO RECORDS SUBPOENA SERVICE, 19775 Washtenaw, Harper Woods, MI 48225

The purpose(s) of this disclosure is:

☐ I authorize the following person(s) and entities to disclose my PHI to BCBSM, BCN or BCMI (circle one).

The purpose(s) of this disclosure is:

Section D: Expiration and Revocation

This authorization will expire on: _____; OR when the following occurs: _____

I understand that I can revoke this authorization at any time by submitting a written request on a standard form, available by calling 313-225-9000. I understand that revocation will not affect actions taken before receipt of my request.

Section E: Signature

_____ Signature

_____ Date

If you are not the member, please sign and write today's date below, then check the box that describes your relationship to the member. If you are not the parent of the member, please attach proof of your relationship to the member.

Print Name of Personal Representative: _____

_____ Signature of Personal Representative

_____ Date

☐ Parent ☐ Legal Guardian ☐ Power of Attorney ☐ Executor ☐ Other _____

Mailing Instructions
Please mail completed authorizations to the BCBSM, BCN or BCMI teams that will release the PHI. Members who are unsure of the mailing address should call a customer service representative at the number on the back of their Blues ID card, or the Blues operator at 313-225-9000.

WE WILL MAIL YOU A COPY OF THIS SIGNED AUTHORIZATION.

INSTRUCTIONS FOR COMPLETING THE AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

An authorization is not valid unless it is filled out completely. Please print or type the information.

Section A: Authorization

1) Member's first and last name
2) Member's full street address, including city, state and ZIP code
3) Subscriber's contract number as it appears on the BCBSM/BCN/BCMI ID card
4) Member's telephone number, including area code

Section B: Use and Disclosures

1) List in detail the information to be used and disclosed (for example, provider's name, dates of treatment, type of service, etc. Check the box if disclosure includes PHI regarding information related to AIDS, ARC, HIV).
2) BCN and BCMI members must check the appropriate boxes for disclosures that:
   a. Include PHI related to substance abuse (including alcoholism)
   b. Include PHI related to mental health services

Section C: Authorized Uses and Disclosures

1) If the member is requesting that BCBSM, BCN or BCMI disclose his or her PHI, please check "I authorize BCBSM, BCN or BCMI (circle one) to disclose my PHI to the following person(s) and entities I" and list to whom the PHI will be disclosed as well as the purpose for the disclosure. You may simply state "at my request" if appropriate.
2) If the member is requesting that others disclose his or her PHI to BCBSM, BCN or BCMI, please check "Disclosure to BCBSM, BCN or BCMI" and list the person(s) who will disclose the information. You may simply state "at my request" if appropriate.

Section D: Expiration and Revocation

1) Fill in the date upon which the authorization will expire (day, month and year) or the event or activity that will trigger expiration of the authorization.
2) Members can revoke authorizations at any time. Revocations must be submitted using the standard BCBSM revocation form. Members can get the forms by calling (313) 225-9000.

Section E: Signature

Members must sign and date the authorization.

1) If a personal representative is signing the authorization form on behalf of a member, the representative must sign his or her name in the space below the signature line and specify his or her relationship to the member by checking the appropriate box below the signature.
2) If the personal representative is someone other than the parent of a minor child named as the patient, he or she must attach proof of signature authority.

The signer will receive a copy of the completed authorization form via return mail. The operating unit that processes the authorization will retain the original.

Mailing Instructions

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