Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Authorization for Use and Disclosure of Protected Health Information

Use this form to authorize us[1] to disclose protected health information to an individual other than yourself, or to allow us to collect protected health information from another entity on your behalf.

Section A: Authorization — I authorize the use and disclosure of my protected health information as described below. I understand that my treatment, payment, enrollment or eligibility for benefits does **not** depend on whether I sign this authorization.

Name		Daytime phone number
Address		
City	State	ZIP	Enrollee ID
	MI		

Check below if you are a:

☒ Blue Cross Blue Shield of Michigan member ☐ Blue Care Network member

☐ Blue Cross Complete of Michigan member

Section B: Description of protected health information to be disclosed — Describe the information that you would like us to disclose or collect (you can state "any and all"):

Any and all records as kept in your system regarding myself.

Please check below if you would like your authorization to include the following information:

☑ **Substance abuse records** (including alcoholism) ☐ **AIDS or HIV treatment records**

☑ **Mental health services** (this excludes psychotherapy notes — use form 7656 to authorize the disclosure of psychotherapy notes)

Section C: Recipient — State who you want to receive protected health information. *If information is disclosed to persons or organizations that are not subject privacy laws, it may be redisclosed and no longer protected.*

☑ I authorize Blue Cross Blue Shield of Michigan, Blue Care Network, Blue Care Network Service Company, Blue Care of Michigan, Inc. or Blue Cross Complete of Michigan to disclose my protected health information to:

CD Services, Inc. (248) 476-1700

24027 Research Drive Farmington Hills, MI 48335

The purpose of this disclosure is (you may state "at my request"): At My Request

[1] "We" or "us" refers to Blue Cross Blue Shield of Michigan, Blue Care Network, Blue Care Network Service Company, Blue Care of Michigan, Inc. or Blue Cross Complete of Michigan.

☐ I authorize Blue Cross Blue Shield of Michigan, Blue Care Network, Blue Care Network Service Company, Blue Care of Michigan, Inc. or Blue Cross Complete of Michigan to collect my protected health information from:

The purpose of this disclosure is (you may state "at my request"): _____

Section D: Expiration and revocation

This authorization will expire on: _____ or when this occurs: 1 year from signature date
Date

I understand that I can revoke this authorization at any time by submitting a written request on a standard form, available online at **bcbsm.com** or by calling 313-225-9000. I understand that revocation will not affect actions taken prior to our receipt of any revocation request.

Section E: Signature

_____ _____
Signature Date

Section F: Authorized representative — If you are not the patient, please sign and date below and check the box that describes your relationship to the member. **If you are not the parent, please attach proof of your relationship to the member (for instance, a power of attorney form or personal representative documentation).**

I am legally entitled to act as the patient's authorized representative because:

☐ I am the parent and the patient is my minor child ☐ I am the patient's legal guardian
☐ I have power of attorney ☐ I am the executor of the patient's estate
☐ Other (please explain): _____

Printed name of authorized representative: _____

Signature of authorized representative: _____

THIS SPACE IS INTENTIONALLY LEFT BLANK

Instructions for Completing the
***Authorization for Use and Disclosure of Protected Health Information* form**

Fill out the form completely. The authorization is not valid unless it is completely filled out.

- This form cannot be used as a joint authorization with another member. Submit a separate form for each member.
- Please type or print the information.

Section A: Authorization. Include the following information about the member whose protected health information is being disclosed:

1) Member's first and last name
2) Member's full street address, including city, state and ZIP code
3) Member's enrollee ID or contract number as it appears on the member's Blue Cross Blue Shield of Michigan, Blue Care Network, Blue Care of Michigan, Inc., Blue Care Network Service Company or Blue Cross Complete of Michigan ID card
4) Member's telephone number, including area code

Check the appropriate box for the member's health care coverage provider. For Blue Care Network Service Company and Blue Care of Michigan, select the box designated "Blue Care Network member."

Section B: Description of protected health information to be disclosed

1) List the information to be used and disclosed. (For example, you can put "any and all" or list the specific claims or dates covered by the authorization.)
2) Check the appropriate box if you wish to disclose the following types of protected health information:
   a. Substance abuse (including alcoholism)
   b. AIDS or HIV treatment records
   c. Protected health information related to mental health services (excluding psychotherapy notes)

Section C: Authorized recipient of the protected health information

1) If you want us to disclose protected health information, check the first box and list the person or entity the protected health information will be disclosed to. Include the person's first and last name when you want to authorize a specific individual to receive your protected health information.
2) Please describe the purpose for the disclosure. You may simply state "at my request" if appropriate.
3) If you are authorizing another person or entity (such as a hospital or doctor) to release protected health information to us, please check the second box and list the person or entity you are authorizing to provide protected health information to us.
4) Once again, describe the purpose for the disclosure. You may simply state "at my request" if appropriate.

Section D: Expiration and revocation

1) Fill in the date when the authorization will expire (day, month and year) or the event or activity that will trigger expiration of the authorization (for instance, "until revoked" or "upon my death").
2) Members can revoke authorizations at any time. Revocations must be submitted using the standard Blue Cross Blue Shield of Michigan revocation form. Members can get the form online at **bcbsm.com** or by calling 313-225-9000.

Section E: Signature — Members must sign and date the authorization unless the form is completed by their personal representative (see below).

Section F: Personal representative

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 signature line, include the date, and specify his or her relationship to the member by checking the appropriate box below the signature.
2) The personal representative must print his or her name, relationship to the member and authority to sign. If the personal representative is someone other than the parent of a minor child, we require written proof.

The signer will receive a copy of the completed authorization form in the mail. We'll keep the original authorization form on file.

Mailing instructions	Faxing instructions
Mail completed authorizations to: Blue Cross Blue Shield of Michigan Mail Code X420 600 East Lafayette Blvd. Detroit, MI 48226	Fax completed authorizations to: **1-866-894-3101**

Members who need additional assistance completing this form should call a Customer Service representative at the number listed on the back of their Blue Cross ID card or call the Blue Cross operator at 313-225-9000 between 8:30 a.m. and 5 p.m., Monday through Friday. TTY users should call 711.