Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use this form to authorize Blue Cross Blue Shield of Michigan (BCBSM), Blue Care Network (BCN), Blue Care Network Service Company (BCNSC), Blue Care of Michigan, Inc. (BCMI) and/or Blue Cross Complete of Michigan to disclose your protected health information (PHI) to an individual other than yourself. If you are completing this form for yourself, please fill out Sections A through E. If you filling out this form on behalf of someone else, please complete Sections A through D and Section F.

Section A: Authorization - I authorize the use and disclosure of my protected health information (PHI) as described in Sections B and C. 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
ADDRESS			
CITY	STATE	ZIP	ENROLLEE ID

☒ Check here if you are a Blue Care Network Member

☐ Check here if you are a Blue Cross Complete of Michigan

Section B: Description of PHI to Be Disclosed - Describe in detail the PHI to be used and disclosed (you can state 'any and all' or provide specific information such as the providers, dates of treatment, or type of service that you would like to disclose):

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

Please check if your authorization will include the disclosure of the following types of PHI:

☒ **Substance abuse** (including alcoholism)

☐ **AIDS, AIDS-related complex, or HIV**

☒ **Mental Health Services** (excluding psychotherapy notes – use form 7656 to authorize the disclosure of psychotherapy notes)

Section C - Authorized Recipient of the PHI: State who you are authorizing to receive PHI. *If PHI is disclosed under your authorization to persons or organizations that are not subject to federal or state privacy laws, it may* be re-disclosed and no longer protected.

☒ I authorize you to disclose my PHI to the following person(s) and entities:

C D Services, Inc. 248-476-1700

24027 Research Drive, Farmington Hills MI, 48335

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

☐ I authorize the following person or entity to disclose my PHI to BCBSM, BCN, BCNSN, BCMI and/or Blue Cross Complete of Michigan:

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

CDS JOB#_____

Section D - Expiration and Revocation

This authorization will expire on: _____ OR when the following 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 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: Personal Representative - IF you are filling out this form on behalf of someone else, please, sign and date below, and check the box that describes your relationship to the member. Additionally, if you are not a parent, filling out this form on behalf of your child, please attach proof of your relationship to the member (e.g., Power of Attorney, personal representative documentation).

Printed Name of Personal Representative: _____

Signature of Personal Representative: _____

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