HAP Midwest Health Plan
HIPAA Form 3C.1

Authorization for Use or Disclosure of Information

I, _____, hereby authorize Midwest Health Plan ("the Plan") to use or disclose the following protected health information:
(Specifically describe the information to be used or disclosed, including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.)

ENTIRE CONTENT OF CLAIM FILES, SUMMARY OF SUBSCRIBERS, PAYMENT HISTORY TO PROVIDERS, EXPLANATION OF BENEFITS (EOB) REVIEWS, DEFINITIONS OF CODES ON EOB OR EOR, ANY OTHER RECORDS.

The protected health information may be disclosed to: (*Insert name of person or entity who may have receive the information)* C D SERVICES, INC.
24027 RESEARCH DRIVE
FARMINGTON HILLS MI, 48335

This protected health information is being used or disclosed for the following purposes: (*List specific purposes here, the member may indicate that the information to be disclosed is "at the member's request" if the member does not choose to provide an explanation of the purpose of the request)*

AT MY REQUEST FOR ALL PURPOSES ALLOWABLE, PERMITTED, OR REQUIRED BY LAW.

This authorization shall be in force and effect until: (check one of the following)

Date _____

- ☒ The happening of the following expiration event:
  ONE YEAR FROM DATE EXECUTED
- ☐ End of research study
- ☐ No expiration (can only be used if authorization is for research)

at which time this authorization to use or disclose this protected health information expires.

CDS JOB#_____

I understand that, as set forth in the Plan's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to:

HAP Midwest Health Plan
4700 Schaefer Rd. Ste. 340
Dearborn, MI 48126
ATTN: Privacy Officer

If you need help completing this form, call 1-888-654-2200.

I understand that a revocation is not effective to the extent that the Plan has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that treatment will not be conditioned on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to

- Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.

_____ _____

Signature of Member or Personal Representative Date

_____

Name of Member or Personal Representative

_____

Description of Personal Representative's Authority