Family Health Center
of Blue Care Network

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use this form to authorize the Family Health Center of Blue Care Network to disclose your protected health information (PHI) to an individual other than yourself or as specified and permitted in our Notice of Privacy Practices. If you are the patient, please complete sections A through E of this form. If you are not the patient please also complete section F, in addition to A through D.

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 CODE	CONTRACT NUMBER	DATE OF BIRTH

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, dates of treatment, 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, BCMI, BCN SC, and BlueCaid of MI 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 Uses and Disclosures as described in Section B

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

☐ I authorize the Family Health Center to disclose my PHI to the following person(s) and entities:

____

The purpose(s) of this disclosure is:

____

☐ I authorize the following person(s) and entities to disclose my PHI to the Family Health Center

____

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: Patient Signature

______________________________ Signature ______________ Date

Section F: Personal Representative

If you are not the patient, please also complete, sign and date section F of this form. Check the box that describes your relationship to the member. **Please attach proof of your relationship to the patient** (e.g. Power of Attorney personal representative documentation)

Print Name of Personal Representative: ______________________________

Signature of Personal Representative: ______________________________

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

Mail to: Family Health Center/Medical Records
1401 Creyts Road,
Lansing, MI 48917

Or, fax to: (517) 322-8044.

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

The Authorization is not valid unless it is filled out completely. This form can not be used as a joint authorization with another member; therefore, each member must submit an individual form. Please type or print 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, BCNSC, or BlueCaid of MI 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) BCBSM, BCN, BCMI, BCNSC, or BlueCaid of MI 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, BCMI, BCNSC, or BlueCaid of MI disclose his or her PHI, please check "I authorize BCBSM, BCN, BCMI, BCNSC, or BlueCaid of MI (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, BCMI, BCNSC, or BlueCaid of MI, please check "Disclosure to BCBSM, BCN, BCMI, BCNSC, or BlueCaid of MI" 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

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 and date in 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 original authorization form will be kept on file.