



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	
ADDRESS	CITY	STATE	ZIP
DATE OF BIRTH	CONTRACT NUMBER		

Section B: PHI Use and Disclosure (NOTE: Use Form # BCNHC 8401MR 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.):

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

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 Disclosure

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 BC to disclose my PHI, described in Section B, 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 Centers of BCN:

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 sending a written request on a standard form, available from the BCN Family Health Center where I receive care. I understand that revocation will not affect actions taken before the BCN receives my request.

Section E: Signature

Signature: _____ Date: _____

If you are not the patient, please sign and write today's date below, then check the box that describes your relationship to the patient. If you are not the parent of the patient, please attach proof of your relationship to the patient. NOTE: An authorization is required if you are not the personal representative.

Print Name of Personal Representative: _____

Signature of Personal Representative: _____ Date: _____

Parent Legal Guardian Power of Attorney Executor Other _____

Please return this form to the Family Health Center where you receive your care:

Family Health Center – Creyts Road 1401 S. Creyts Road Lansing, MI 48917	Family Health Center – Lake Lansing 1525 W. Lake Lansing Road East Lansing, MI 48823	Former patients of Fashion Square, Essexville, and Midland Family Health Centers return forms to: Family Health Center – Creyts Road 1401 S. Creyts Road Lansing, MI 48917
---	---	--

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

The Authorization is not valid unless it is filled out completely. Please type or print the information.

Section A: Authorization

- 1) Patient’s first and last name
- 2) Patient’s full street address, including city, state and ZIP code
- 3) Patient’s date of birth
- 4) Patient’s phone number, including area code

Section B: PHI Use and Disclosure

- 1) List in detail the protected health information to be used and disclosed.
BCN and BCMI members must check the appropriate boxes, if applicable, for disclosures that:
 - a. Include PHI related to substance abuse (including alcoholism)
 - b. Include PHI related to mental health services

Section C: Authorized Use and Disclosures

- 1) If the patient would like the FHC to disclose his or her PHI, check “Disclosure by the FHC” and list to whom the information shall be disclosed and the purpose for the disclosure. If at your request, simply state “at my request.”

If the member is requesting that others disclose his or her PHI to the FHC, check “Disclosure to the FHC” and list the person(s) who will disclose the information. If at your request, simply state “at my request.”

Section D: Expiration and Revocation

- 1) Fill in the date when the authorization will expire (day, month and year) or, if applicable, the event or activity that will trigger expiration of the authorization.
- 2) If the patient wishes to revoke the authorization, he or she may do so at any time. The request must be submitted in writing using the standard FHC revocation form. The patient may obtain a standard form by calling the FHC where he or she received care.

Section E: Signature

The patient must sign and date the authorization.

- a. If a personal representative signs the authorization on behalf of a member, the representative must sign his or her name on the line below the patient signature line and specify his or her relationship to the member by checking the appropriate box below the signature.
- b. 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.

Please return this form to the Family Health Center where you receive your care:

Family Health Center – Creyts Road 1401 S. Creyts Road Lansing, MI 48917	Family Health Center – Lake Lansing 1525 W. Lake Lansing Road East Lansing, MI 48823	Former patients of Fashion Square, Essexville, and Midland Family Health Centers please return forms to: Family Health Center – Creyts Road 1401 S. Creyts Road Lansing, MI 48917
---	--	--