



## AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use this form to authorize BCBSM, BCN, BCN SC, BCMI and BlueCaid of MI 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 member, please complete sections A through E of this form. If you are not the member 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 & 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	CONTRACT NUMBER

**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, treatment dates, 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-disclosed and no longer protected.

I authorize BCBSM, BCN, BCMI, BCNSC, or BlueCaid of MI (circle one) 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 BCBSM, BCN, BCMI, BCNSC, or BlueCaid of MI (circle one).

\_\_\_\_\_

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: Member Signature**

\_\_\_\_\_  
Signature Date

**Section F: Personal Representative**

If you are not the member, 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 member** (e.g. Power of Attorney personal representative documentation)

Print Name of Personal Representative: \_\_\_\_\_

\_\_\_\_\_  
Signature of Personal Representative Date

- Parent of minor child  Legal Guardian  Power of Attorney  Executor  Other \_\_\_\_\_

**Mailing Instructions**

Please mail completed authorizations to BCBSM, Mail Code X320, 600 East Lafayette Blvd., Detroit, Michigan 48226. Members who need additional assistance completing this form should call a customer service representative at the number on the back of their Blues ID card, or the Blues operator at 313-225-9000. **WE WILL MAIL YOU A COPY OF THIS SIGNED AUTHORIZATION**