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-disclosed and no longer protected.

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

RECORDS DEPOSITION SERVICE, INC.
P.O. BOX 5054, SOUTHFIELD, MI 48086-5054 P: 248-357-3330 F: 248-357-3337

The purpose(s) of this disclosure is:
FOR DISCOVERY BEFORE TRIAL

☐ 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: Blue Cross Blue Shield of Michigan
53200 Grand River, MC L809
New Hudson, MI 48165

Or, fax to: (877) 351-4571
Telephone number: 248-486-2187