Member Consent for Release of Protected Health Information

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Use this form to allow Blue Cross* to share your protected health information (also known as PHI) with an individual or organization.

A Member who is giving consent

This form can only be used for one member. Please submit a separate form for each member.

Name _____ **Date of birth** _____

Enrollee ID (number on ID card beginning with 1 to 3 letters) _____

Address _____ **Daytime phone** _____

City _____ **State** _____ **ZIP** _____

B Protected health information to be shared *(check one)*

- ☐ Any and all information (including personal, health, demographic, claims, billing and medical records)
- ☐ Only limited information (such as for specific treatments, dates of service or billing details)

(please describe) _____

Please check below if you would also like to include any of the following highly protected information (known as Super PHI):

- ☐ Substance abuse records (including alcoholism)
- ☐ AIDS or HIV treatment records
- ☐ Mental health services (does not include psychotherapy notes)

C Person or organization that may receive your information

Note: If information is shared with a person or organization that is not legally required to obey privacy laws, the information may be shared with others and no longer protected.

Print first and last name for a person, and the most detailed name possible for an organization (for example, hospital name and department).

Recipient's full name _____

Please check the box below describing the person or organization's relationship to you.

- ☐ Family member
- ☐ Friend
- ☐ Doctor or health care provider
- ☐ Other *(describe)* _____

Form continues on page 2.

* "Blue Cross," "we" or "us" refers to Blue Cross Blue Shield of Michigan, Blue Care Network, Blue Care Network Service Company, Blue Care of Michigan, Inc. or Blue Cross Complete of Michigan.

D Expiration and cancellation

This permission will expire *(check one box only)*:

☐ On this date (month, day and year, MM/DD/YYYY) _____

☐ When canceled, or upon my death

I understand that I can cancel this authorization at any time by submitting a written request on a standard form, available online at **bcbsm.com** or by calling the number listed on the back of my ID card. I understand that cancellation will not apply to information that has been released by this authorization.

E Authorization and signature

I allow the use and disclosure of my protected health information as described above. This information is being released at my request. I understand that my treatment, payment, enrollment or eligibility for benefits does not depend on whether I sign this authorization.

Signature of member

SIGN HERE _____ Date _____

IMPORTANT: Please read the form over carefully and be sure you have included all necessary information. We cannot take additional information by phone, fax or email. If information is missing we will have to contact you and request a new form.

Mail completed consent form to:

Blue Cross Blue Shield of Michigan
Mail Code X420
600 East Lafayette Blvd.,
Detroit, MI 48226

or fax to: **1-866-894-3101.**

For additional assistance completing this form, call the number listed on the back of the member's ID card.

Medicare Plus Blue, BCN Advantage and Prescription Blue are PPO, HMO, HMO-POS and PDP plans with Medicare contracts. Enrollment in Medicare Plus Blue, BCN Advantage and Prescription Blue depends on contract renewal.