Blue Cross Blue Shield of Michigan
Blue Care Network of Michigan
BCN Service Company
BlueCaid of Michigan

AUTHORIZATION FOR USE AND DISCLOSURE OF PSYCHOTHERAPY NOTES

Section A: Authorization

I authorize the use and disclosure of my psychotherapy notes 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	CONTRACT NUMBER

Section B: Information for Use and Disclosure

Describe in detail the psychotherapy notes to be used and disclosed (providers, treatment dates, etc.):

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 BCBSM, BCN, BCN SC, BCMI or BlueCaid of MI (circle one) to disclose my psychotherapy notes, described in Section B, 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 psychotherapy notes BCBSM, BCN, BCN SC, BCMI 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 can revoke this authorization at any time by sending a written request on a standard form, available by calling 313-225-9000. I understand that revocation will not affect actions taken prior to your receipt of my revocation request.

Section E: Signature

_____ _____
Signature Date

If you are not the member, please sign and write today's date below, then check the box that describes your relationship to the member. If you are not the parent of the member, please attach proof of your relationship to the member.

Print Name of Personal Representative: _____

_____ _____
Signature of Personal Representative Date

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

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.