DISCLAIMER: NOT FOR USE FOR MARKETING, RESEARCH OR UNDERWRITING PURPOSES
[OR PSYCHOTHERAPY NOTES]

Great Lakes Health Plan Authorization for Disclosure of Personal and Health Information

Name _____ Address _____

Social Security No. _____ City/State/Zip _____

Medicaid No._____ Date of Birth _____

I request and authorize Great Lakes Health Plan to disclose my personal and health information. I understand that my personal and health information may include claims and billing information, medical records created by medical practitioners that Great Lakes Health Plan received, including records regarding general medical care, alcohol and drug abuse treatment, psychological or psychiatric treatment, social services counseling, human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or AIDS related complex (ARC), communicable diseases or infections, venereal diseases, tuberculosis and hepatitis, and demographic information. I understand that Great Lakes Health Plan will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

- Information to be disclosed (choose one):
  - ☐ Claims Information
  - ☐ Payment Information
  - ☐ Enrollment/Eligibility Information
  - ☐ Utilization Information
  - ☐ Medical Management Information
  - ☒ Other: All documents available
- Disclosure is to be made to (name, address, zip code, phone #):
  Records Deposition Service, Inc., P.O. Box 5054, Southfield, MI 48086-5054
  (248) 357-3330
- This authorization expires in one year or on the following date: _____, whichever time period is shorter.
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- I understand that I may refuse to sign this authorization and that I may revoke it at any time but I must do so in writing to Great Lakes Health Plan, at the following address. The revocation will not be effective to the extent that Great Lakes Health Plan has already disclosed the information. I understand that I have the right to receive a copy of this authorization after it is signed if the Great Lakes Health Plan requested it. I understand that the persons to whom information is disclosed under this Authorization may possibly re-disclose the information to others without my knowledge or consent and therefore the privacy of my personal and health information may no longer be protected by law.

_____ _____

Signature of Member or Authorized Representative Date Signed

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If signed by a person other than the member, please state relationship and authority to do so and provide proof of legal relationship.

_____ Legal Guardian

____ Power of Attorney

_____ Parent of minor child

_____ Personal Representative of living or deceased

Please return the signed authorization by mail or facsimile to:

Great Lakes Health Plan, Inc.
Attn: Legal Department
17117 West Nine Mile Road-Suite 1600
Southfield, MI 48075
Fax: 248-559-4640