McLaren
HEALTH PLAN

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use this form to authorize McLaren Health Plan (MHP), McLaren Health Plan Community (MHP Community) or McLaren Health Advantage (MHA) to disclose your protected health information (PHI) to an individual other than you or as specified and permitted in our Notice of Privacy Practices. **If you are the member, please complete sections A – E of this form. If you are someone other than the member, please complete sections A – D and section F.**

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. I also understand that my PHI may be re-disclosed by the recipient, in which case it may no longer be protected under HIPAA.

NAME:		DAYTIME PHONE NUMBER:	
ADDRESS:			
CITY:	STATE:	ZIP:	CONTRACT NUMBER:

Section B: PHI Use and Disclosure
Describe in detail the PHI to be used and disclosed (claim information, providers, dates of treatment, type of service, etc.):

PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST

Please check if your authorization includes the disclosure of PHI regarding:
- ☐ Testing or treatment for AIDS, AIDS-related complex or HIV
- ☐ Substance abuse (including alcoholism)
- ☐ Mental health services (excluding psychotherapy notes)

Section C: Authorized Uses and Disclosures of the PHI described in Section B.
1. ☑ I authorize McLaren Health Plan (MHP), McLaren Health Plan Community (MHP Community), and/or McLaren Health Advantage (MHA), to disclose my PHI to the following person(s) or entities:

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

2. The purpose(s) of the disclosure is **"at my request" or other:**
LEGAL - FOR DISCOVERY BEFORE TRIAL

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 (888) 327-0671. I understand that revocation will not affect actions taken before receipt of my request.

Section E: Signature of Member:

_____ _____
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 patient*** *(e.g., Power of Attorney)*

Print Name of Personal Representative: _____

Signature of Personal Representative: _____ Date: _____

☐ Parent of Minor child ☐ Legal Guardian* ☐ Power of Attorney * ☐ Executor* ☐ Other* _____

* If you are one of these persons you must provide proof of authority to act for the member.

G-3245 Beecher Road • Flint, Michigan • 48532
tel (888) 327-0671 • fax (877) 502-1567
MclarenHealthPlan.org