Authorization to Release Information [Please print]

This form is used to release your protected health information as required by federal and state privacy laws. Your authorization allows the Health Plan (your health insurance carrier or HMO) to release your protected health information to a person or organization that you choose. You can revoke this authorization at any time by submitting a request in writing to the Health Plan (contact Member Services for further instructions). Revoking this authorization will not affect any action taken prior to receipt of your written request.

Member Information: (individual whose information will be released)

Name: (First, Middle, Last, Title)		**Date of Birth:** (Month/Day/Year)
Address: (including zip code)		**Telephone Number:** (including area code)
Group Name/Number: (if available)	**Social Security Number:** (optional)	**Member ID Number:**

Health Plan: (organization that will release your information)

I authorize _____ to release my protected health information as described below.
(Health Plan name on your ID card)

Recipient: (person or organization that will receive your information)

Person's Name or Organization: Records Deposition Service	**Telephone Number:** (including area code) (248) 357-3330
Address: (including zip code) P.O. Box 5054, Southfield, MI 48086-5054	**Fax Number:** (if available) (248) 357-3337

Description of the Information to be Released: (what type of information will be released)

Check only one box:

☐ **Psychotherapy notes** – Federal law requires an authorization to use or release psychotherapy notes.
If you check this box, you may not check another box below.

☐ **All information related to the provision of and payment for my health care benefits or services.***

☒ **Specific information described below:***
all information including claims, payments, etc.
Examples: The claim related to my service on (date); Appeal information related to my claim on (date)

Purpose of Release: legal discovery
Examples: At my request; To resolve my appeal; To assist with my health insurance services

***NOTE**: State law requires that you give specific permission to release the information below even if you checked a box above. Indicate your permission for the Health Plan to release any of the following information by initialing all that apply.

Genetic Information _____ (Initials) **HIV/AIDS** _____ (Initials)
Substance/Alcohol Abuse _____ (Initials) **Mental/Behavioral Health** _____ (Initials)

Expiration: (when this authorization will end)

This authorization will expire on ____/____/____(mm/dd/yyyy) **OR** on the occurrence of the following event:

_____
Examples: Until I revoke this authorization; Resolution of a specific issue

Approval: (You OR your personal representative must sign and date this form in order for it to be complete.)

I understand that this authorization to release information is voluntary and is not a condition of enrollment in this Health Plan, eligibility for benefits, or payment of claims. I also understand that if the person or organization I authorize to receive the information described above is not subject to federal health information privacy laws, they may further release the protected health information and it may no longer be protected by federal privacy laws.

Member Signature: By signing below, I authorize the use of my protected health information.	**Personal Representative Information:** A personal representative is a person who has the legal authority to act on behalf of an individual. A copy of a Power of Attorney or other court-related legal document must be on file at the health plan.
_____ (Signature of Member)	_____ (Printed Name of Personal Representative) _____ (Date) (____)_____ (Telephone Number)
_____ (Date)	_____ (Signature of Personal Representative) _____ (Description of representative's authority)

PLEASE KEEP A COPY OF THIS FORM AND THE INSTRUCTIONS FOR YOUR RECORDS