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:

____

The purpose(s) of this disclosure is:

____

☐ 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 minor child ☐ Legal Guardian ☐ Power of Attorney ☐ Executor ☐ Other _______________________

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.

BCBSM and its licensed controlled affiliates are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.

INSTRUCTIONS FOR COMPLETING THE AUTHORIZATION FOR USE AND DISCLOSURE OF PSYCHOTHERAPY NOTES

An authorization is not valid unless it is filled out completely. This form can not be used as a joint authorization with another member; therefore, each member must submit an individual form. Please print or type the information.

Section A: Requesting an Authorization

1) Member's first and last name
2) Member's full street address, including city, state and ZIP code
3) Subscriber's contract number as it appears on his or BCBSM, BCN, BCN SC, BCMI or BlueCaid of MI ID card
4) Member's telephone number, including area code

Section B: Information for Use and Disclosure

1) List in detail the information to be used and disclosed (for example, provider's name, dates of treatment, type of service, etc.).

Section C: Authorized Use and Disclosure

1) List all persons and entities the individual authorizes to disclose (release) psychotherapy notes described in section B to BCBSM, BCN, BCN SC, BCMI and BlueCaid of MI. If at your request, you may simply state "at my request."
2) Detail the purposes for which the individual authorizes BCBSM, BCN, BCN SC, BCMI and BlueCaid of MI to use the psychotherapy notes described in section B. If at your request, you may simply state "at my request."

Section D: Expiration and Revocation

1) Fill in the date on which the individual wants the authorization to expire (day, month and year) or, if applicable, the event or activity that will trigger the expiration of the authorization.
2) Individuals can revoke authorization at any time by submitting a completed standard BCBSM revocation form. To get a form, call (313) 225-9000.

Section E: Signature

The member must sign and date the authorization.

1) If a personal representative is signing the authorization form on behalf of a member, the representative must sign his or her name in the space below the signature line and specify his or her relationship to the member by checking the appropriate box below the signature.
2) If the personal representative is someone other than the parent of a minor child named as the patient, he or she must attach proof of signature authority.

The signer will receive a copy of the completed authorization form via return mail. The original authorization form will be kept on file.

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