



AUTHORIZATION FOR USE AND DISCLOSURE OF PSYCHOTHERAPY NOTES

Use of this form to authorize BCBSM, BCN, BCNSC, BCMI and Blue Caid of Michigan to disclose your protected health information (PHI) to an individual other than yourself or as specified and permitted in our Notice of Privacy Practices. If you are not the member, please also complete Section F, in addition to A through D.

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 CODE	ENROLLEE ID

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 to 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

Section F: Personal Representative

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 _____

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

The 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 type or print the information

Section A: Authorization

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

Section B: Use and Disclosures

- 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 Uses and Disclosures

- 1) If the member is requesting that BCBSM, BCN, BCMI, BCNSC, or BlueCaid of MI disclose his or her Psychotherapy Notes, please check "I authorize BCBSM, BCN, BCMI, BCNSC, or BlueCaid of MI (circle one) to disclose my Psychotherapy Notes to the following person(s) and entities" **and list to whom the Psychotherapy Notes will be disclosed** as well as the purpose for the disclosure. You may simply state "at my request" if appropriate.
- 2) If the member is requesting that others disclose his or her PHI to BCBSM, BCN, BCMI, BCNSC, or BlueCaid of MI, please check "Disclosure to BCBSM, BCN, BCMI, BCNSC, or BlueCaid of MI" and list the person(s) who will disclose the information. You may simply state "at my request" if appropriate.

Section D: Expiration and Revocation

- 1) Fill in the **date upon which the authorization will expire (day, month and year) or the event or activity** that will trigger expiration of the authorization.
- 2) Members can revoke authorizations at any time. Revocations must be submitted using the standard BCBSM revocation form. Members can get the forms by calling (313) 225-9000.
- 3) Provide a brief description of the purpose of this disclosure

Section E: Signature

Members must sign and date the authorization.

Section F: Personal Representative

- 1) If a personal representative is signing the authorization form on behalf of a member, the representative must sign his or her name and date in 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.

A copy of this form will be kept on file. The original will be returned to the signer via United States Postal Services (U.S. Mail).

Mailing Instructions

Please mail completed authorizations to BCBSM, Mail Code **X420**, 600 E. 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.

FAXING INSTRUCTIONS

Please **FAX** completed authorizations to **1-866-894-3101**. 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.