Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

# AUTHORIZATION FOR USE AND DISCLOSURE OF PSYCHOTHERAPY NOTES

Use this form to authorize Blue Cross Blue Shield of Michigan, Blue Care Network, Blue Care Network Service Company, Blue Care of Michigan, Inc. and/or Blue Cross Complete of Michigan to disclose your protected health information to an individual other than yourself or as specified and permitted in our Notice of Privacy Practices. If you are filling out this form on behalf of someone else, please complete Section F, in addition to Sections 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 | ENROLLEE ID |

☐ Check here if you are a Blue Cross Blue Shield of Michigan member
☐ Check here if you are a Blue Care Network member
☐ Check here if you are a Blue Cross Complete of Michigan member

**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 –** State who you are authorizing to receive your psychotherapy notes. *If psychotherapy notes are disclosed under your authorization to persons or organizations not subject to federal or state privacy laws, it may be redisclosed and no longer protected.*

☐ I authorize you to disclose my psychotherapy notes to the following person(s) and entities:

The purpose(s) of this disclosure is (you may state "at my request"): _____

☐ I authorize the following person(s) and entities to disclose my psychotherapy notes to Blue Cross Blue Shield of Michigan, Blue Care Network, Blue Care Network Service Company, Blue Care of Michigan, Inc. and/or Blue Cross Complete of Michigan:

The purpose(s) of this disclosure is (you may state "at my request"): _____

**Section D: Expiration and revocation**

This authorization will expire on: _____ OR when the following occurs: _____
*Date*

I understand that I can revoke this authorization at any time by submitting a written request on a standard form, available online or by calling 313-225-9000. I understand that revocation will not affect actions taken prior to our receipt of any revocation request.

**Section E: Signature**

_____ _____
*Signature* *Date*

**Section F: Personal representative –** If you are not the patient, please sign and date section F of this form. Check the box that describes your relationship to the member. **If you are not the parent, please attach proof of your relationship to the member (e.g., power of attorney, personal representative documentation, etc).**

Printed name of personal representative: _____

Signature of personal representative and date: _____

☐ Parent of minor child ☐ Legal guardian ☐ Power of attorney ☐ Executor ☐ Other

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

**Fill out the form completely**. The authorization is not valid unless it is filled out completely.

- This form cannot be used as a joint authorization with another member; therefore, each member must submit a separate form
- Please type or print the information

**Section A: Authorization.** Please include the following information about the member whose protected health information is being disclosed:

1) Member's first and last name.
2) Member's full street address, including city, state and ZIP code.
3) Include the member's enrollee ID/contract number as it appears on the member's Blue Cross Blue Shield of Michigan, Blue Care Network, Blue Care Network Service Company, Blue Care of Michigan, Inc., or Blue Cross Complete of Michigan ID card.
4) Member's telephone number, including area code.
5) Check the appropriate box for your health care coverage provider. For Blue Care Network Service Company and Blue Care of Michigan, Inc., please select the box designated "Blue Care Network member."

**Section B: Information for use and disclosure**

1) List the information to be used and disclosed (for example you can put "any and all" or list the specific claims or dates covered by the authorization).

**Section C: Authorized uses and disclosures**

1) If you want us to disclose any psychotherapy notes in our possession, check the first box and list the person or entity to whom the protected health information will be disclosed. Include: first and last name when you want to authorize a specific individual to receive your protected health information.
2) If the member is requesting that others disclose his or her protected health information to Blue Cross Blue Shield of Michigan, Blue Care Network, Blue Care Network Service Company, Blue Care of Michigan, Inc., or Blue Cross Complete of Michigan, please check "Disclosure to Blue Cross Blue Shield of Michigan, Blue Care Network, Blue Care Network Service Company, Blue Care of Michigan, Inc., or Blue Cross Complete of Michigan" 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 (e.g. until revoked or upon my death).
2) Members can revoke authorizations at any time. Revocations must be submitted using the standard BCBSM revocation form. Members can get the forms online at **bcbsm.com** or by calling 313-225-9000.

**Section E: Signature – Members must sign and date the authorization** unless the form is completed by their personal representative (see below).

**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) The personal representative must print his or her name and relationship to the member and authority to sign. If the personal representative is someone other than the parent of a minor child, written proof is required.

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

| Mailing instructions | Faxing instructions |
|---|---|
| Please mail completed authorizations to:<br>BCBSM<br>Mail Code **X425**<br>600 E. Lafayette Blvd.<br>Detroit, MI 48226 | Please fax completed authorizations to:<br>**1-866-894-3101**. |

Members who need additional assistance completing this form should call a customer service representative at the number listed on the back of their Blues ID card, or the Blues operator at 313-225-9000.

## We speak your language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 877-469-2583 TTY:711، إذا لم تكن مشتركا بالفعل.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話；如果您還不是會員，請撥電話 877-469-2583, TTY: 711。

ئەگەر تۆ، یان کەسێک کە یارمەتی دەدەیت، پێویستی بە یارمەتی هەیە، مافی ئەوەت هەیە بە بێ هیچ تێچوونێک یارمەتی و زانیاری پێویست بە زمانەکەت وەربگریت. بۆ قسەکردن لەگەڵ وەرگێڕێک، پەیوەندی بە ژمارەی خزمەتگوزاری بەکارهێنەرانەوە بکە کە لەسەر کارتەکەت هەیە، یان 877-469-2583 TTY:711، ئەگەر ئەندام نیت.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하거나, 이미 회원이 아닌 경우 877-469-2583, TTY: 711로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন বা 877-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiama il 877-469-2583, TTY: 711 se non sei ancora membro.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号 (メンバーでない方は877-469-2583, TTY: 711) までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру 877-469-2583, TTY: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTY: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

## Important disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711, fax: 866-559-0578, email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.