



**AUTHORIZATION FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

SECTION A: INFORMATION ABOUT YOU

MEMBER NAME:			MEMBER NUMBER:
MEMBER ADDRESS:			MEMBER GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
CITY:	STATE:	ZIP:	MEMBER DATE OF BIRTH:
DAYTIME PHONE NUMBER:		EVENING PHONE NUMBER:	

SECTION B: PHI USE AND DISCLOSURE

I authorize and request the use and disclosure of my Protected Health Information (PHI), including, without limitation, my name and the following as applicable protected under the regulations in Title 42 of Code of Federal Regulations Part II:

- Diagnosis and/or treatment of alcoholism and/or drug abuse or dependency;
- Diagnosis and/or treatment of mental illness;
- Human Immunodeficiency Virus-HIV, Acquired Immunodeficiency Syndrome-AIDS, and AIDS related complex-ARC, as defined by the Department of Community Health Rules (1989 Public Act 174);
- Genetic testing information.

Please indicate what information you wish to release by checking one or more of the boxes below. If you wish to grant limited access (specific dates, providers, claims or issues, etc.), please specify in the space provided.

- Claims: _____
- Eligibility/Benefits: _____
- Medical Records: _____
- Case Management: _____
- Other: _____

SECTION C: AUTHORIZED USES AND DISCLOSURES

PLEASE 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 PHP to disclose my PHI to the following person(s) and/or entities:

NAME or ENTITY:			
ADDRESS:			GENDER if applicable <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
CITY:	STATE:	ZIP:	DATE OF BIRTH if applicable
DAYTIME PHONE NUMBER:		EVENING PHONE NUMBER:	

The purpose(s) of this disclosure is:

SECTION D: EXPIRATION

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

I understand that I may revoke this designation at any time by sending a written notification to PHP at the address below. I further understand that any such revocation does not apply to the extent that PHP has already acted in reliance on this designation.

SECTION E: SIGNATURE

Signature

Date

(If the above signature is that of a member's representative, PHP must complete the following)

I have verified the identification of:

Name of Representative:

Documentation Type:

Documentation Number:

Caregiver Signature

Date

Please return Authorization to:

**Physicians Health Plan
PO Box 30377
Lansing, MI 48909-7877
Fax to: 517.364.8406
Email to: PHPCompliance@phpmm.org**

SECTION F: REVOCATION – ONLY USE THIS PORTION TO REVOKE PR

I, _____ hereby revoke authorization for use and disclosure of my protected health information, as given above.

Signature

Date

(If the above signature is that of a member's representative, PHP must complete the following)

I have verified the identification of:

Name of Representative:

Documentation Type:

Documentation Number:

Caregiver Signature

Date

FOR HEALTH PLAN USE ONLY

Accepted

Date Logged:

Reviewed By:

Denied

If Denied, Why:

Sent To:

Date Sent:

Language Access Information

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-800-649-3777 (TTY: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-649-3777 (TTY: 711).

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (رقم هاتف الصم والبكم): 800-649-377 (TTY: 711)-1

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-649-3777 (TTY: 711)

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-649-3777 (TTY: 711).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-649-3777 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-649-3777 (TTY: 711) まで、お電話にてご連絡ください

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-649-3777 (TTY: 711) 번으로 전화해 주십시오.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-649-3777 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-649-3777 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-649-3777 (TTY: 711).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-649-3777 (TTY: 711).

Bengali: লক্ষ্য করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-১৮০০-৬৪৯-৩৭৭৭ (TTY: 711)।

Albanian: KUJDE: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-649-3777 (TTY: 711).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-649-3777 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Syriac:

1-800-649-3777 (TTY: 711)