INSTRUCTIONS FOR COMPLETING:

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) FORM

The Authorization is not valid unless it is filled out completely and signed. Please type or print the information.

Section A: Information About You

Enter the name, address, member number (found on the PHP ID card), phone numbers and date of birth for the individual for whom the authorization pertains.

Section B: PHI Use and Disclosure

1. List in detail the information to be used and/or disclosed. For example, a provider's name, dates of treatment, type of service, enrollment records, claims records, etc.
2. Check the appropriate boxes for disclosures that include PHI related to substance abuse, mental health services, or testing or treatment for AIDS, AIDS-related complex or HIV. If these do not apply to you, leave them blank.

Section C: Authorized Uses and Disclosures

1. If you are requesting that PHP disclose your PHI, please check "I authorize PHP to disclose PHI to the following person(s) and/or entities," and
   - List to whom the PHI will be disclosed; and
   - The purpose for the disclosure (you may simply state "at my request" if appropriate)
2. If you are requesting that others disclose your PHI to PHP, please check "I authorize the following person(s) and/or entities to disclose my PHI to PHP," and
   - List the person(s) who will disclose the information to PHP; and
   - The purpose for the disclosure (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. You may revoke authorizations at any time. Revocations must be submitted to PHP in writing. Revocation of an authorization will not affect actions taken before PHP received the written request to revoke authorization.

Section E: Signature

The authorization must be signed before it becomes valid.

1. If a personal representative is signing the authorization form on your behalf, the representative must print and sign his/her name in the spaces below the signature line, and specify his/her relationship to you by checking the appropriate box below the signature.
2. If the personal representative is someone other than the parent of a minor child who is the subject of the authorization, he/she must attach proof of signature authority.
3. You may assign a personal representative by completing the Designation of Personal Representative Form.

PHYSICIANS HEALTH PLAN (PHP)
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

SECTION A: Information About You

I authorize the use and disclosure of my Protected Health Information (PHI) 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:				
ADDRESS:				**GENDER:** ☐ **MALE** ☐ **FEMALE**
CITY:	**STATE:**	**ZIP:**	**MEMBER NUMBER:**	
DAYTIME PHONE NUMBER:	**EVENING PHONE NUMBER:**			**DATE OF BIRTH (mm/dd/yyyy):**

SECTION B: PHI Use and Disclosure

Describe in detail the PHI to be used and disclosed (providers, treatment dates, type of service, enrollment records, claims records, etc.)

_____

_____

_____

Please check if your authorization includes the disclosure of PHI regarding:

☐ Substance abuse (including alcoholism)
☐ Mental health services
☐ Testing or treatment for AIDS, AIDS-related complex or HIV

SECTION C: Authorized Uses and Disclosures of Information Described in Section B

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:

_____

The purpose(s) of this disclosure is:

_____

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

_____

The purpose(s) of this disclosure is:

_____

SECTION D: Expiration and Revocation

This authorization will expire on: ____/____/____ ; OR when the following occurs: _____
Enter Date of Expiration

I understand that I can revoke this authorization at any time by submitting a written request to PHP. I understand that revocation will not affect actions taken before PHP receives my request to revoke authorization.

SECTION E: Communication of This Authorization to PHP's Associated Providers of Service

We will send your authorization to our associated providers of service on your behalf with your permission. Please check all that apply.

☐ Pharmacy Benefit Manager
☐ Mental Health/Substance Abuse Designate
☐ Transplant Network
☐ None

SECTION E: Signature

_____ _____
Signature Date

*If you are not the member, please sign and 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 Date

☐ Parent ☐ Legal Guardian ☐ Power of Attorney ☐ Executor ☐ Other: _____

Mailing Instructions: Please mail completed authorization to **Physicians Health Plan, PO Box 30377 Lansing, MI 48909-7877**
Telephone: 517-364-8400

You will receive a copy of this signed authorization, upon your request, or if PHP requested that you complete the form.

FOR HEALTH PLAN USE ONLY

Reviewed By: _____ ☐ Accepted ☐ Denied Date Logged: _____

If Denied, Why: _____

Sent To & Date(s) _____