Physicians Health Plan

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

SECTION A: INFORMATION ABOUT YOU

MEMBER NAME:			**MEMBER NUMBER:**
MEMBER ADDRESS:			**MEMBER GENDER:** ☐ **MALE** ☐ **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** ☐ **MALE** ☐ **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 E: 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: