McLaren HEALTH PLAN

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use this form to authorize McLaren Health Plan (MHP), McLaren Health Plan Community (MHP Community) or McLaren Health Advantage (MHA) to disclose your protected health information (PHI) to an individual other than you or as specified and permitted in our Notice of Privacy Practices**. If you are the member, please complete sections A – E of this form. If you are someone other than the member, please complete sections A – D and section F.**

Section A: Authorization

I authorize the use and disclosure of my protected health information (PHI) as described in Sections B and C. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization. I also understand that my PHI may be re-disclosed by the recipient, in which case it may no longer be protected under HIPAA.

NAME:			DAYTIME PHONE NUMBER:
ADDRESS:			
CITY:	STATE:	ZIP:	CONTRACT NUMBER:

Section B: PHI Use and Disclosure

Unless noted below, the authorized individuals in Section C can obtain your PHI from your initial coverage date with MHP.

☐ Only respond to inquiries from: (*insert date*) _____to: (*insert date*) _____

Describe in detail the PHI that can be released (*Please check all that apply*):

☐ Claims information (Medical)
☐ Enrollment/benefits
☐ Claims information (Pharmacy)
☐ Precertification/referral information
☐ All of the above (*Does not include below*)
☐ Other (*Please specify*) _____

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

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

Section C: Authorized Uses and Disclosures of the PHI described in Section B.

1. ☐ I authorize McLaren Health Plan (MHP), McLaren Health Plan Community (MHP Community), and/or McLaren Health Advantage (MHA), to disclose my PHI orally or in writing to the following person(s) or entities:
   _____
2. The purpose(s) of the disclosure is (*Please check one*):
   ☐ At my request ☐ Other (*please specify*) _____

Section D: Expiration and Revocation (*Please check one*)

This authorization will expire:

☐ 1 year from the date of my signature
☐ 3 years from the date of my signature
☐ 5 years from the date of my signature
☐ On the following date (*insert date*) _____
☐ On the following event (*please specify*) _____

I understand that I can revoke this authorization at any time by submitting a written request on a standard form, available by calling (888) 327-0671. I understand that revocation will not affect actions taken before receipt of my request.

Section E: Signature of Member:

_____ _____

Signature **Date**

Section F: Personal Representative:

If you are not the member, please also complete, sign and date Section F of this form. Check the box that describes 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*_____

* If you are one of these persons you must provide proof of authority to act for the member.

G-3245 Beecher Road • Flint, Michigan • 48532
tel (888) 327-0671 • fax (877) 502-1567
McLarenHealthPlan.org

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

INSTRUCTIONS FOR COMPLETING THE AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Authorization is not valid unless it is filled out completely. This form cannot be used as a joint authorization with another member. **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. Contract number as it appears on the McLaren Health Plan, McLaren Health Plan Community or McLaren Health Advantage ID card
4. Member's telephone number, including area code

Section B: Use and Disclosures

Please check the box(es) detailing the information to be used and disclosed (for example, claims data, provider's name, dates of treatment, type of service, etc.) Check the appropriate box(es) if disclosure includes PHI regarding information related to AIDS, ARC or HIV, substance abuse or mental health services.

Section C: Authorized Uses and Disclosures

Please indicate your authorization for us to release your PHI to the designated person(s) by checking the box, "I authorize McLaren Health Plan (MHP), McLaren Health Plan Community (MHP Community), and/or McLaren Health Advantage (MHA), to disclose my PHI to the following person(s) or entities:", and list the names of the companies or persons to whom PHI should be disclosed as well as the purpose for the disclosure. **Note:** You may simply check the box, "at my request" if appropriate.

Section D: Expiration and Revocation

Check the box or fill in the date upon which the authorization will expire (day, month and year) or the events that will trigger expiration of the authorization.

1. Members can revoke authorizations at any time. Revocations must be submitted using a standard McLaren revocation form.
2. You can get the forms by calling us at (888) 327-0671.

Section E: Signature

Members must sign and date the authorization; OR

Section F: Personal Representative

1. If a personal representative is signing the authorization form on behalf of a member, the representative must sign and date the form in Section F and specify his/her relationship to the member by checking the appropriate box.
2. If the personal representative is someone other than the parent of a minor child named as the member, he/she must attach proof of authority.

Mailing Instructions

Please mail completed authorizations to:

ATT: Privacy Officer
McLaren Health Plan
P.O. Box 1511
Flint, MI 48501-1511

You should keep a copy of the signed form for your file. We will retain the original in our files for the time-period required by law.

Faxing Instructions

You may also fax a completed authorization to us at (810) 733-5788, ATT: Privacy Officer, McLaren Health Plan. Members who need additional assistance completing this form should call a Customer Service Representative at (888) 327-0671.

Emailing Instructions

You may also email the authorization to us. Scan/save the completed, signed form to: MHPcompliance@mclaren.org.