Member Consent for Release of Protected Health Information

Blue Cross Blue Shield Blue Care Network of Michigan

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

Use this form to allow Blue Cross* to share your protected health information (also known as PHI) with an individual or organization.

A Member who is giving consent

This form can only be used for one member. Please submit a separate form for each member.

Name ____________________ **Date of birth** ____________

Enrollee ID (number on ID card beginning with 1 to 3 letters) ____________

Address ____________________ **Daytime phone** ____________

City ____________________ **State** ________ **ZIP** ________

B Protected health information to be shared *(check one)*

☑ Any and all information (including personal, health, demographic, claims, billing and medical records)

☐ Only limited information (such as for specific treatments, dates of service or billing details)

*(please describe)*____________________

Please check below if you would also like to include any of the following highly protected information (known as Super PHI):

☐ Substance abuse records (including alcoholism)

☐ AIDS or HIV treatment records

☐ Mental health services (does not include psychotherapy notes)

C Person or organization that may receive your information

Note: If information is shared with a person or organization that is not legally required to obey privacy laws, the information may be shared with others and no longer protected.

Print first and last name for a person, and the most detailed name possible for an organization (for example, hospital name and department).

Recipient's full name Legal-Ease Digital Imaging - PO Box 1017, Flint, MI 48501-1017

Please check the box below describing the person or organization's relationship to you.

☐ Family member

☐ Friend

☐ Doctor or health care provider

☒ Other *(describe)* Record Retrieval Company

Form continues on page 2.

* "Blue Cross," "we" or "us" refers 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.

D Expiration and cancellation

This permission will expire *(check one box only)*:

☐ On this date (month, day and year, MM/DD/YYYY) ______________________

☐ When canceled, or upon my death

I understand that I can cancel this authorization at any time by submitting a written request on a standard form, available online at **bcbsm.com** or by calling the number listed on the back of my ID card. I understand that cancellation will not apply to information that has been released by this authorization.

E Authorization and signature

I allow the use and disclosure of my protected health information as described above. This information is being released at my request. I understand that my treatment, payment, enrollment or eligibility for benefits does not depend on whether I sign this authorization.

Signature of member

SIGN HERE ______________________________ Date ______________

IMPORTANT: Please read the form over carefully and be sure you have included all necessary information. We cannot take additional information by phone, fax or email. If information is missing we will have to contact you and request a new form.

Mail completed consent form to:

Blue Cross Blue Shield of
Michigan Mail Code X425
600 East Lafayette Blvd.,
Detroit, MI 48226

or fax to: **1-866-894-3101.**

For additional assistance completing this form, call the number listed on the back of the member's ID card.

Medicare Plus Blue, BCN Advantage and Prescription Blue are PPO, HMO, HMO-POS and PDP plans with Medicare contracts. Enrollment in Medicare Plus Blue, BCN Advantage and Prescription Blue depends on contract renewal.

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Request For Access To Designated Protected Health Information Records

Use this form to request to inspect or obtain copies of your protected health information in the designated record set that we or our business associates, maintain.

Please provide the following information:

Name			Daytime phone number
Address			
City	State	ZIP code	Enrollee ID

You have the right to inspect or obtain a copy of protected health information in your designated record (except certain limited information, including: copies of psychotherapy notes, information we have compiled in anticipation of, or for use in a, civil, criminal or administrative action or proceeding, and certain other records). Elements in the designated record may include: eligibility, enrollment, payment, claims, appeals and case or medical management records. Unless you indicate otherwise, we will provide a summary of the records.

1. I am requesting:

☐ A summary of all records maintained in the designated record set:

From: ______________ ______________
Month Year

To: ______________ ______________
Month Year

☑ Specific records:

Any and All Insurance Records, Claims, Billings, Claims Paid, Reports, Accident Reports, Medical Records and any other records

2. Does this request include information about services received at a Blue Care Network Health Center? ☐ Yes ☐ No

3. The manner in which you prefer to access your records:

☐ Paper copies mailed to: ______________________________
Name of recipient

____
Street address

____
City, state, ZIP code

☐ In person. I would like to review the records in person at a location designated by Blue Cross Blue Shield of Michigan or Blue Care Network.

(Please complete the form on the opposite side)

☑ Electronically. Please select the format to receive your copies:

☐ PDF

☐ Other (please specify): ____________________

I would like my electronic copies delivered to:

☑ An email address: Pat Clifford - Legal-Ease Digital Imaging, LLC
Name of recipient

pat.legalease@gmail.com
Email address of recipient

☐ A postal address: ____________________
Name of recipient

____
Street address

____
City, state and ZIP code

Please send the copies on a: ☐ CD-ROM
☐ USB storage device
☐ Other (please specify) ____________________

4. Please sign and date:

____________________ ____________________
Signature *Date*

If you are not the member, please sign and write today's date below, then check the box that describes your relationship to the member. If you are not the parent of a minor member, please attach proof of your relationship to the member. An authorization is required if you are not the personal representative.

Name of personal representative: ____________________

Signature of personal representative and date: ____________________

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

Please include the fax number as shown below.
Please mail completed form (and all documentation if needed) to: **Customer Individual Rights Unit**
BCBSM
600 East Lafayette, MC CS3A
Detroit, MI 48226-2998

or Fax to: **1-877-348-2210**

Blue Cross Blue Shield of Michigan will make reasonable attempts to produce the designated record in the form and format you have requested. However, in the event that we cannot produce the records in the form and format you have requested, we have the right to contact you to establish a mutually agreeable alternative. We reserve the right to charge a reasonable fee to produce the copies in the form and format you have requested.