HealthPlus™

Authorization for Release of Personal and Health Information

For HealthPlus of Michigan and its Subsidiaries

Note: Release of Information May Vary with Individual State Laws and Regulations – Please consult Legal Department for Non-Michigan Members

Subscriber Name _____ Member Date of Birth _____

Subscriber Number _____ Subscriber Address _____

Member Number _____ City/State/Zip _____

1. Disclosure is to be made to:

Name Legal-Ease Digital Imaging, LLC Address P.O. Box 1017

Telephone Number 855-534-4003 City/State/Zip Flint, MI 48501-1017

Relationship to Subscriber _____

2. I request and authorize HealthPlus of Michigan, Inc., or its subsidiaries (HealthPlus) to disclose to the individual listed above the following of my personal and health information that HealthPlus maintains (check all that you are authorizing):

- ☐ Claims and billing information.
- ☐ Medical records created by medical practitioners that HealthPlus received, including records regarding general medical care, alcohol and drug abuse treatment, psychological or psychiatric treatment, social services counseling, human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or AIDS related complex (ARC), communicable diseases or infections, venereal diseases, tuberculosis and hepatitis.
- ☐ Sickle Cell Anemia Information (Authorization Required for U.S. Veterans Only)
- ☐ Demographic information.

This information does not include psychotherapy notes recorded by a mental health professional during a counseling session.

3. Information to be disclosed:

- ☐ Claims information
- ☐ Enrollment information
- ☐ Case Management information
- ☐ Eligibility information
- ☐ Other information: _____

Date Span of Information (Be Specific): From: _____ To: _____ Date Needed by:

4. This authorization permits the use and disclosure of personal and health information for marketing purposes as described below:

☐ Yes ☐ No

Marketing is defined as a communication about a product or service that encourages recipients of the communication to purchase or use the product or service. Marketing does not include communications that are made by HealthPlus or its agents:

a) for the purpose of describing a health-related product or service (or payment for such product or service) that is provided by, or included in a plan of benefits of, HealthPlus;

b) to an individual as part of the treatment of the individual, and for the purpose of furthering the treatment of that individual; or

c) to an individual in the course of managing or coordinating the treatment of that individual, or for the purpose of directing or recommending to that individual alternative treatments, therapies, health care providers, or settings of care.

5. HealthPlus will not receive remuneration from a third party for the use of this personal and health information.

6. Purpose of the disclosure:

- ☐ at the request of the individual
- ☐ marketing purpose: _____
- ☐ other: _____

7. This authorization expires (choose one):

- ☐ one year from the date it is signed
- ☐ on the following date: _____

8. I understand that I may refuse to sign this authorization and that I may revoke it at any time, but I must do so in writing to HealthPlus at the following address:

HealthPlus of Michigan, Inc.
Customer Service Department
2050 South Linden Road
P. O. Box 1700
Flint, MI 48501-1700

9. This request shall not apply to information released prior to the signed date of this document.

10. I understand that I have the right to receive a copy of this authorization after it is signed.

11. I understand that the persons to whom information is disclosed under this Authorization may possibly re-disclose the information to others without my knowledge or consent and therefore the privacy of my personal and health information may no longer be protected by law.

12. I understand that HealthPlus will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

_____ _____
Signature Date Signed

If signed by a person other than the member, please state relationship and authority to do so:

- ☐ Parent of minor child
- ☐ Legal Guardian
- ☐ Power of Attorney
- ☐ Personal Representative of deceased

PLEASE MAIL OR FAX THIS COMPLETED FORM TO:

HealthPlus of Michigan
P.O. Box 1700
Flint, MI 48501-1700
Attention: Customer Service Department
Fax 810-496-8440

VERIFICATION:
HealthPlus has verified the identity of the member's representative by reviewing the attached document (e.g., driver's license, power of attorney, order appointing guardian, order appointing personal representative of the deceased, etc.) and he/she is authorized to act in that capacity on the behalf of the member.

_____ _____
Signature of HealthPlus staff Date Signed