

Each member to be covered on the contract over the age of 18 will need to complete an authorization. Parents and/or legal guardians **must complete an authorization for each minor on the contract under the age of 18.**

***Additional copies may need to be made, one per person needed for application.***

**Section A - Requesting an Authorization**

I authorize the use and disclosure of my protected health information as described in Section B below. I understand that my enrollment in BCS can be conditioned upon my authorization to release Protected Health Information (PHI) for underwriting purposes. My signature on this form indicates my approval for the release of PHI from BCBSM and from my provider(s) to BCBSM.

I understand that if I do not provide authorization, I may not be eligible for enrollment in BCS. If BCBSM discloses this information, the recipient must obtain an additional authorization from me before it may re-disclose the information. Otherwise, information disclosed under this authorization may be re-disclosed by the recipient and no longer protected.

Name	Social Security Number	Phone Number	
Address	City	State	Zip
Applicant Name			

**Section B — Information for Use/Disclosure**

(NOTE: A different form must be used if you are authorizing the use/disclosure of psychotherapy notes.)

Describe in detail the information to be used or disclosed (providers, dates of treatment, type of service, etc.):

**Past membership and claims history stored on the Blue Cross Blue Shield of Michigan computer systems and past treatment information from the providers identified below in Section C.**

Check here if your authorization includes the disclosure of information regarding AIDS, ARC or HIV testing/treatment

**Section C — Authorized Uses I Disclosures**

**Disclosure by BCBSM:**

I authorize BCBSM to disclose my protected health information described in Section B to the following persons and/or entities for their use: **BCS and Michigan Dental Association**

I authorize the persons and / or entities listed above to use my protected health information described in Section B for the following purposes: **Medical underwriting and enrollment**

**Disclosure to BCBSM:**

I authorize the following persons and/or entities to disclose my protected health information described in Section B to BCBSM: \_\_\_\_\_

I authorize BCBSM to use my protected health information described in Section B for the following purposes:

**Medical underwriting and enrollment** List all doctors named on application:

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## **Section D — Expiration and Revocation**

This authorization will expire: **On** \_\_\_\_\_ ; OR when the following occurs: **Upon enrollment or rejection of coverage**

I may revoke this authorization at any time by sending a written request on a standard form available by contacting my Michigan Dental Association office. I understand that revocation will not affect actions taken before receiving my request.

## **Section E — Signature**

\_\_\_\_\_  
Signature Date

If a personal representative signs this authorization on behalf of the individual, specify your relationship to the individual including your authority to sign.

Personal Representative's Name: \_\_\_\_\_

Relationship to the individual and authority to sign: \_\_\_\_\_

(Unless you are the **parent of a minor** child, please provide proof of your relationship to the individual.)

**WE WILL PROVIDE YOU A COPY OF THIS SIGNED AUTHORIZATION**

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

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The Authorization is not valid unless it is filled out completely.

## **Section A: Requesting an Authorization**

- 1) Fill in the member's first and last name
- 2) Fill in the member's full street address, including city, state and ZIP code
- 3) Fill in the subscriber's social security number
- 4) Fill in the member's telephone number, including area code
- 5) Fill in the applicant's name

## **Section C: Authorized Uses / Disclosures**

- 1) Review and check both boxes.
- 2) In the Disclosure to BCBSM section, fill in the names of treatment providers as indicated for this member on the Family Health Statement form included with the submitted Enrollment Application.

## **Section D: Expiration and Revocation**

- 1) If the member would like to revoke the authorization he/she may do so at any time. The request must be submitted in writing using the standard revocation form. The member may obtain a standard form by calling their Michigan Dental Association office.

## **Section E: Signature**

- 1) Member must sign and date the authorization. If the individual that signs the authorization form is a personal representative, the individual must specify the relationship to the member.
- 2) The personal representative must print his/her name and detail relationship to member and authority to sign. If the personal representative is someone other than the parent of a minor child, written proof must be provided.

The requesting individual must be provided a copy of the completed authorization form. The original authorization form should be saved in the operating unit where authorization was processed for future review and action surrounding the authorization.

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**Internal Use Only**

**BCBSM/BCN ONLY**

**This document needs to be retained and stored according to departmental procedures.**