

HEALTHPLUS OF MICHIGAN

Authorization for Release of Personal and Health Information

1. Member Name _____ Member No. _____
Subscriber No. _____ Member Date of Birth _____

I request and authorize HealthPlus of Michigan, Inc., or its subsidiaries (HPM) to release my personal and health information that HPM has which may include:

- a) claims and billing information;
- b) medical records created by medical practitioners that HPM 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; and
- c) demographic information.

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

2. Release of information is to be made to:

Name: _____

Address: _____

Relationship to Subscriber _____

City, State, Zip: _____

Telephone number: _____

3. This authorization expires (choose one):

- one year from the date it is signed
- upon expiration of insurance coverage
- on the following date: _____

4. The revocation will not be effective to the extent that HPM has already released the information.

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

6. I understand that the persons to whom information is released under this Authorization may possibly re-release the information to others without my knowledge or consent as described in the HPM Notice of Privacy Practices.

7. 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 HPM at the following address:

PLEASE MAIL OR FAX THIS COMPLETED FORM TO:

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

8. I understand that HPM will not base treatment, payment, enrollment or eligibility for benefits on if I sign this authorization.

Signature

Date Signed

If signed by a person other than the member, please state relationship and authority to do so (**proof of relationship must be attached and returned with this signed authorization**):

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

VERIFICATION:

HPM 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 HPM staff

Date Signed