

This form is intended to serve as a sample for Michigan attorneys assisting clients with forms for HIPAA compliance. Under HIPAA preemption standards a HIPAA form is not intended to replace a current form being used in compliance with applicable Michigan law. Use of the sample HIPAA forms will require integration of the HIPAA sample form with existing forms currently in use. The attorney also may wish to consult the HIPAA Matrix to determine if any preemption issue under Michigan law needs to be addressed in the form. This form is for educational purposes only and does not constitute, and may not be relied upon, as legal advice.

DISCLAIMER: NOT FOR USE FOR MARKETING, RESEARCH OR UNDERWRITING PURPOSES
[OR PSYCHOTHERAPY NOTES]

Health Plan Authorization for Release of Personal and Health Information

Name _____ Address _____

Social Security No. _____ City/State/Zip _____

Medicaid No. _____ Date of Birth _____

I request and authorize Health Plan to release my personal and health information that Health Plan has which may include claims and billing information, medical records created by medical practitioners that Health Plan 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 demographic information. I understand that Health Plan will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

- Information to be disclosed: (choose one) All of my personal and health information
 All claims and billing information only
 Other: _____
- Disclosure is to be made to (name, address, zip code, phone #): _____

- Purposes of the disclosure: _____ At the request of the individual
_____ Other
- This authorization expires (choose one): One year from the date it is signed
 On the following date: _____

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 Health Plan, at the following address. The revocation will not be effective to the extent that Health Plan has already disclosed the information. I understand that I have the right to receive a copy of this authorization after it is signed if the Health Plan requested it. 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.

Signature

Date Signed

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

_____ Legal Guardian

_____ Power of Attorney

_____ Parent of minor child

_____ Personal Representative of
deceased