



# AUTHORIZATION FOR USE AND DISCLOSURE OF PSYCHOTHERAPY NOTES

## Section A: Authorization

I authorize the use and disclosure of my psychotherapy notes as described in Sections B and C below. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

NAME		DAYTIME PHONE NUMBER	
ADDRESS			
CITY	STATE	ZIP	CONTRACT NUMBER

## Section B: Information for Use and Disclosure

Describe in detail the psychotherapy notes to be used and disclosed (providers, treatment dates, etc.):

\_\_\_\_\_

## Section C: Authorized Use and Disclosure

NOTE: If PHI is disclosed under your authorization to persons or organizations not subject to federal privacy laws, it may be redisclosed and no longer protected.

I authorize BCBSM, BCN or BCMI (check one) to disclose my psychotherapy notes, described in Section B, to the following person(s) and entities:

Axiom Requisition Copy Service, 447 North Canal Road, Lansing, MI 48917

The purpose(s) of this disclosure is:

\_\_\_\_\_

I authorize the following person(s) and entities to disclose my psychotherapy notes to BCBSM, BCN or BCMI (circle one).

The purpose(s) of this disclosure is:

\_\_\_\_\_

## Section D: Expiration and Revocation

This authorization will expire on: \_\_\_\_\_; OR when the following occurs: \_\_\_\_\_

\_\_\_\_\_

I can revoke this authorization at any time by sending a written request on a standard form, available by calling 313-225-9000. I understand that revocation will not affect actions taken prior to your receipt of my revocation request.

## Section E: Signature

\_\_\_\_\_  
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 the member, please attach proof of your relationship to the member.

Print Name of Personal Representative: \_\_\_\_\_

\_\_\_\_\_  
Signature of Personal Representative Date

Parent  Legal Guardian  Power of Attorney  Executor  Other \_\_\_\_\_

## Mailing Instructions

Please mail completed authorizations to the BCBSM, BCN or BCMI team that will release the PHI. Members who are unsure of the mailing address should call a customer service representative at the number on the back of their Blues ID card, or the Blues operator at 313-225-9000.

**WE WILL MAIL YOU A COPY OF THIS COMPLETED AND SIGNED AUTHORIZATION.**

INSTRUCTIONS FOR COMPLETING THE AUTHORIZATION  
FOR USE AND DISCLOSURE OF PSYCHOTHERAPY NOTES

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An authorization is not valid unless it is filled out completely. Please print or type the information.

**Section A: Requesting an Authorization**

- 1) Member's first and last name
- 2) Member's full street address, including city, state and ZIP code
- 3) Subscriber's contract number as it appears on his or her BCBSM, BCN or BCMI ID card
- 4) Member's telephone number, including area code

**Section B: Information for Use and Disclosure**

- 1) List in detail the information to be used and disclosed (for example, provider's name, dates of treatment, type of service, etc.).

**Section C: Authorized Use and Disclosure**

- 1) List all persons and entities the individual authorizes to disclose (release) psychotherapy notes described in section B to BCBSM, BCN and BCMI. If at your request, you may simply state "at my request."
- 2) Detail the purposes for which the individual authorizes BCBSM, BCN and BCMI to use the psychotherapy notes described in section B. If at your request, you may simply state "at my request."

**Section D: Expiration and Revocation**

- 1) Fill in the date on which the individual wants the authorization to expire (day, month and year) or, if applicable, the event or activity that will trigger the expiration of the authorization.
- 2) Individuals can revoke authorization at any time by submitting a completed standard BCBSM revocation form. To get a form, call (313) 225-9000.

**Section E: Signature**

**The member must sign and date the authorization.**

- 1) If a personal representative is signing the authorization form on behalf of a member, the representative must sign his or her name in the space below the signature line and specify his or her relationship to the member by checking the appropriate box below the signature.
- 2) If the personal representative is someone other than the parent of a minor child named as the patient, he or she must attach proof of signature authority.

The signer will be provided a copy of the completed authorization form via return mail. The operating unit that processes the authorization will retain the original.

**Mailing Instructions**

Please mail the completed form to the team within BCBSM, BCN or BCMI that you want to release your information. If you are unsure of the mailing address, please call your customer service representative at the number on the back of your Blues ID card, or call the Blues operator at 313-225-9000.