

**HealthPlus of Michigan, HealthPlus Partners, HealthPlus Options, HealthPlus Senior
County Health Plans**

Authorization for Release of Behavioral Health Information

Member Name _____

Member Contract No. _____

Medicaid ID No. _____

Address _____

Date of Birth _____

City/State/Zip _____

1. I request and authorize _____ (Provider) to release to HealthPlus, or its subsidiaries personal health information contained in my patient record.
2. I request and authorize HealthPlus to release my personal and health information to coordinate care between my primary care physician and behavioral health provider and between my inpatient and outpatient behavioral health providers.
3. Information disclosed may include my:
 - a) claims and billing information;
 - b) 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; and
 - c) demographic information.

This information does not include psychotherapy notes (process notes compiled in a psychoanalytical model) recorded by a mental health professional during a counseling session.

4. This authorization will be in effect as long as I participate in HPM on or after the date signed; OR this authorization expires: (choose one)
 one year from the date it is signed
 on the following date: _____
5. 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
Attention: Behavioral Health Services
2050 South Linden Road
P. O. Box 1700
Flint, MI 48501-1700
6. If you choose to revoke this authorization, it will not be effective if HealthPlus has already disclosed the information.
7. I understand that I have the right to receive a copy of this authorization after it is signed.
8. I understand that HealthPlus will **not** withhold 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:

- | | |
|--|--|
| <input type="checkbox"/> Parent of minor child | <input type="checkbox"/> Power of Attorney |
| <input type="checkbox"/> Personal Representative of deceased | <input type="checkbox"/> Legal Guardian |

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