

**Member Authorization for Release  
of Protected Health Information**

Name \_\_\_\_\_

Member ID number \_\_\_\_\_

Telephone number \_\_\_\_\_

Address \_\_\_\_\_

City/State/ZIP \_\_\_\_\_

Date of birth \_\_\_\_\_

I request and authorize Care Choices HMO to disclose my protected health information (including demographic information) held by Care Choices HMO, including claims and billing information, enrollment and eligibility information, and medical management information as indicated in #1 below. This authorization includes disclosures of medical records created by medical practitioners that Care Choices HMO has received, including records regarding general medical care, as well as any alcohol and drug abuse treatment, psychological or psychiatric treatment, social services counseling, and any treatment for human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or AIDS-related complex (ARC), communicable diseases or infections, venereal diseases, tuberculosis and hepatitis, when such information is contained in the requested and authorized types of information indicated in #1 below:

1. Information to be disclosed and time period(s) of disclosures:

A. Type of Information (please check one or more)

- Enrollment/Eligibility Information
- Medical Management Information - including medical records, if any, received from medical practitioners
- Claims and Billing Information

B. Dates of Service (if applicable): \_\_\_\_\_

2. Disclosure is to be made to:

Name(s) \_\_\_\_\_

Address \_\_\_\_\_

City/State/ZIP \_\_\_\_\_

Telephone number \_\_\_\_\_

3. The reason for this disclosure is: (please check one)

- Individual or representative signed below has requested
- In response to subpoena by an attorney
- Other purpose (please state): \_\_\_\_\_

4. This authorization remains in effect from the date it is signed until membership with Care Choices HMO is terminated, unless it is earlier revoked in writing by the Individual or Representative, or unless another expiration date is here specified:

\_\_\_\_\_

I understand that Care Choices HMO will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I understand that I may refuse to sign this authorization and that no disclosure will be made if I refuse. I understand that I may revoke it at any time, but I must do so in writing to the following address: Customer Service Department, Care Choices HMO, P.O. Box 9087, Farmington Hills, MI 48333. The revocation will not be effective to the extent that Care Choices HMO has already disclosed the information. I understand that I have the right to receive a copy of this authorization after it is signed if Care Choices HMO 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 protected health information may no longer be protected by law.

Signature \_\_\_\_\_

Name of person who signed (please print) \_\_\_\_\_

Date \_\_\_\_\_

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

- Legal Guardian
- Parent of minor
- Personal Representative of a deceased or living person
- Power of Attorney
- Patient Advocate Designee

**INSTRUCTIONS**

**Complete and return this authorization (and proof of authority, where applicable) to the person specified below.**

Name \_\_\_\_\_

Department \_\_\_\_\_

Mailing Address: Care Choices HMO  
34605 Twelve Mile Road  
Farmington Hills, MI 48331

Or fax to \_\_\_\_\_

**If name above is blank, please mail to:**

Mailing Address: Customer Service Department  
Care Choices HMO  
P.O. Box 9087  
Farmington Hills, MI 48333

If you have any questions or wish a direct fax number, please call Customer Service at 1-800-852-9780.

**MINUTE MAN  
PROCESS & LEGAL SERVICES  
3318 N. Main  
Royal Oak, MI 48073**