UNIVERSITY OF MICHIGAN HEALTH PLAN
UNIVERSITY OF MICHIGAN HEALTH

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

RESET FORM

SECTION A: INFORMATION ABOUT YOU

MEMBER NAME:			**MEMBER NUMBER:**
MEMBER ADDRESS:			**MEMBER GENDER:** ☐ MALE ☐ FEMALE
CITY:	**STATE:**	**ZIP:**	**MEMBER DATE OF BIRTH:**
DAYTIME PHONE NUMBER:		**EVENING PHONE NUMBER:**	

SECTION B: PHI USE AND DISCLOSURE

I authorize and request the use and disclosure of my Protected Health Information (PHI), including, without limitation, my name and the following as applicable protected under the regulations in Title 42 of Code of Federal Regulations Part II:

☐ Diagnosis and/or treatment of alcoholism and/or drug abuse or dependency;

☐ Diagnosis and/or treatment of mental illness;

☐ Human Immunodeficiency Virus-HIV, Acquired Immunodeficiency Syndrome-AIDS, and AIDS related complex-ARC, as defined by the Department of Community Health Rules (1989 Public Act 174);

☐ Genetic testing information.

Please indicate what information you wish to release by checking one or more of the boxes below. If you wish to grant limited access (specific dates, providers, claims or issues, etc.), please specify in the space provided.

☐ Claims: _____

☐ Eligibility/Benefits: _____

☐ Medical Records: _____

☐ Case Management: _____

☐ Other: _____

SECTION C: AUTHORIZED USES AND DISCLOSURES

PLEASE NOTE: IF PHI IS DISCLOSED UNDER YOUR AUTHORIZATION TO PERSONS OR ORGANIZATIONS NOT SUBJECT TO FEDERAL PRIVACY LAWS, IT MAY BE RE-DISCLOSED AND NO LONGER PROTECTED.

☐ I authorize University of Michigan Health Plan (UM Health Plan) to disclose my PHI to the following person(s) and/or entities:

NAME or ENTITY:			
ADDRESS:			**GENDER if applicable** ☐ **MALE** ☐ **FEMALE**
CITY:	**STATE:**	**ZIP:**	**DATE OF BIRTH if applicable**
DAYTIME PHONE NUMBER:		**EVENING PHONE NUMBER:**	

The purpose(s) of this disclosure is:

_____

SECTION D: EXPIRATION

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

_____

I understand that I may revoke this designation at any time by sending a written notification to UM Health Plan at the address below. I further understand that any such revocation does not apply to the extent that UM Health Plan has already acted in reliance on this designation.

SECTION E: SIGNATURE

_____

Signature Date

(If the above signature is that of a member's representative, UM Health Plan must complete the following)

I have verified the identification of:	**Name of Representative:**
Documentation Type:	**Documentation Number:**

_____

UM Health Plan Associate Signature Date

Please return Authorization to:

University of Michigan Health Plan
P.O. Box 30377
Lansing, MI 48909-7877
800-832-9186 phone
517-364-8411 fax

Revised 08/23/2024

SECTION F: REVOCATION – ONLY USE THIS PORTION TO REVOKE PR

I, _____ hereby revoke authorization for use and disclosure of my protected health information, as given above.

_____

Signature Date

(If the above signature is that of a member's representative, UM Health Plan must complete the following)

I have verified the identification of:	**Name of Representative:**
Documentation Type:	**Documentation Number:**

_____

UM Health Plan Associate Signature Date

FOR HEALTH PLAN USE ONLY			
Accepted ☐	Date Logged:	Reviewed By:	
Denied ☐		If Denied, Why:	
Sent To:			Date Sent:

LANGUAGE ASSISTANCE

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 800.832.9186 (TTY: 711).

Spanish: ATENCIÓN: Si habla español, puede solicitar servicios gratuitos de asistencia lingüística. Llame al 800.832.9186 (TTY: 711).

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المُساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (رقم هاتف الصم والبكم: (TTY: 711) 800.832.9186

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電800.832.9186 (TTY: 711)

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie unter 800.832.9186 (TTY: 711) an.

Italian: ATTENZIONE: Se parla italiano, può disporre di servizi di assistenza linguistica gratuiti. Chiamare il numero 800.832.9186 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800.832.9186 (TTY: 711) まで、お電話にてご連絡ください

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800.832.9186 (TTY: 711) 번으로 전화해 주십시오.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800.832.9186 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, вам доступны бесплатные услуги перевода. Звоните 800.832.9186 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, mayroong mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800.832.9186 (TTY: 711).

Vietnamese: CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số 800.832.9186 (TTY: 711).

Bengali: লক্ষ্য করুনঃ আপনি যদি ইংরেজি ব্যতীত অন্য কোনো ভাষায় কথা বলেন,, তাহলে আপনার জন্য নিখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 800.832.9186 (TTY: 711)।

Albanian: NJOFTIM: Nëse flisni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 800.832.9186 (TTY: 711).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su Vam besplatno. Nazovite 800.832.9186 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Syriac:

ܙܘܗܪܐ: ܐܢ ܐܢܬܘܢ ܟܐ ܡܡܙܡܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܡܨܝܬܘܢ ܕܩܒܠܝܬܘܢ ܝܠܦܢܘܬܐ ܕܡܫܪܝܬܐ ܒܠܫܢܐ ܡܓܢܢܐܝܬ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ 800.832.9186 (TTY: 711)