



AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

This form will serve as authorization for EHIM to receive your protected health information (PHI) from HealthPlus. All family members over the age of 18 years covered under this contract must sign this form. Please indicate below your relationship to any dependent under the age of 18 years. If there are family members covered under this contract that have a different home address than the cardholder, it is acceptable for those members to sign and submit their own form. **This form is for PHI authorization only.**

Section A: PHI Authorization Company: Mott Community College EHIM Member ID:
 I authorize the use and disclosure of my protected health information (PHI) as described in Section B below. I understand that treatment, payment, enrollment, and eligibility will not be conditioned on whether or not I sign this authorization.

Employee Name	Date of Birth	SSN
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Dependent Name	Date of Birth	SSN
If dependent is under the age of 18, please indicate if the Employee is:		
Parent of Minor Child	Legal Guardian	Power of Attorney
	(Circle One)	Other:
	Executor	

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Section B: Expiration

This form serves as authorization for EHIM, Inc. to receive all HealthPlus claims information from all healthcare providers, including but not limited to, service dates, types of service, substance abuse services, mental health services, etc. This form also serves as authorization to EHIM, Inc. to disclose claims information to Health Plus for the purposes of processing claims as a secondary payer

Section C: Expiration

This form will expire when I am no longer an eligible member of the Group HealthPlan or I choose to revoke this authorization. I understand that I can revoke this authorization at any time by submitting a written request to EHIM, Inc. I understand that revocation will not affect actions taken before the confirmed receipt of my request.

Section D: Member Signatures - Signatures are required for dependents 18 years of age and older.

Employee Signature	Print Name	Date
Dependent Signature	Print Name	Date
Dependent Signature	Print Name	Date
Dependent Signature	Print Name	Date
Dependent Signature	Print Name	Date

**Please deliver this form to Ronda Brinch in Human Resources
 This form may also be faxed to (810) 762-0595**