

Member Consent for Release of Protected Health Information



Blue Cross
Blue Shield
Blue Care Network
of Michigan

Nonprofit corporations and independent licensees
of the Blue Cross and Blue Shield Association

Use this form to allow Blue Cross* to share your protected health information (also known as PHI) with an individual or organization.

A Member who is giving consent

This form can only be used for one member. Please submit a separate form for each member.

Name Margaret Bishop Date of birth 10/13/38

Enrollee ID (number on ID card beginning with 1 to 3 letters) _____

Address 3512 Sandhurst Dr. Daytime phone 517-775-4916

City Lansing State MI ZIP 48917

B Protected health information to be shared (check one)

Any and all information (including personal, health, demographic, claims, billing and medical records) except Super PHI. Use the boxes listed below to include Super PHI.

Only limited information (such as for specific treatments, dates of service or billing details)
(please describe) _____

Please check below if you would also like to include any of the following highly protected information (known as Super PHI):

Substance abuse records (including alcoholism)
 AIDS or HIV treatment records
 Mental health services (does not include psychotherapy notes)
 Family Planning
 Psychotherapy notes (excluded from mental health)

C Person or organization that may receive your information

Note: If information is shared with a person or organization that is not legally required to obey privacy laws, the information may be shared with others and no longer protected.

Print first and last name for a person, and the most detailed name possible for an organization (for example, hospital name and department).

Recipient's full name Michael Bishop (Jr.)

Please check the box below describing the person or organization's relationship to you.

Family member (son - Guardian)
 Friend
 Doctor or health care provider
 Other (describe) _____

* "Blue Cross," "we" or "us" refers to Blue Cross Blue Shield of Michigan, Blue Care Network, Blue Care Network Service Company, Blue Care of Michigan, Inc. or Blue Cross Complete of Michigan.

D Expiration and cancellation

This permission will expire (check one box only):

On this date (month, day and year, MM/DD/YYYY) _____

When canceled, or upon my death

I understand that I can cancel this authorization at any time by submitting a written request on a standard form, available online at **bcbsm.com** or by calling the number listed on the back of my ID card. I understand that cancellation will not apply to information that has been released by this authorization.

E Authorization and signature

I allow the use and disclosure of my protected health information as described above. This information is being released at my request. I understand that my treatment, payment, enrollment or eligibility for benefits does not depend on whether I sign this authorization.

Signature of member

SIGN HERE



Date

2/18/25

IMPORTANT: Please read the form over carefully and be sure you have included all necessary information. We cannot take additional information by phone, fax or email. If information is missing we will have to contact you and request a new form.

Mail completed consent form to:

**Blue Cross Blue Shield of
Michigan Mail Code X425
600 East Lafayette Blvd.,
Detroit, MI 48226**

or fax to: **1-866-894-3101**.

For additional assistance completing this form, call the number listed on the back of the member's ID card.

Approved, SCAO

STATE OF MICHIGAN
PROBATE COURT
COUNTY OF INGHAM

JIS CODE: LET

RE-ISSUED
LETTERS OF CONSERVATORSHIP

FILE NO.

22-001060-CA-P33

Estate of MARGARET BISHOP

TO:	Name and address MICHAEL BISHOP JR. 8607 CARLSBAD LANE LANSING, MI 48917	Conservator's telephone no. (517)775-4916
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You have been appointed limited conservator conservator of the estate and are granted power to take possession, collect, preserve, manage, and dispose of property of the estate according to law and to perform all acts permitted or required by statute, court rule, and orders of this court unless limited below.

The conservator shall have authority with respect to all assets of the estate.
 Real estate or ownership interest in a business entity is excluded from your responsibilities in your acceptance of appointment.
 The conservator shall have authority with respect to the following assets only:

Letters of conservatorship expire annually and will not be renewed until all annual filing requirements have been completed by the conservator.

These letters of conservatorship expire: 02/04/2026

Restrictions:

The conservator shall not sell or otherwise dispose of the protected individual's principal dwelling, real property or interest in real property, or mortgage, pledge, or cause a lien to be placed on any such property without a prior order of approval.

01/16/2025

Date

Shauna Dunnings
Judge SHAUNA DUNNINGS

P43714
Bar no.

Attorney name (type or print)

Bar no.

Address

City, state, zip

Telephone no.

SEE NOTICE OF DUTIES ON SECOND PAGE

I certify that I have compared this copy with the original on file and that it is a correct copy of the original, and on this date, these letters are in full force and effect.

Date

Deputy probate register

USE NOTE: If this form is being filed in the circuit court family division, please enter the court name and county in the upper left-hand corner of the form.

Do not write below this line - For court use only

Mailed to Conservator 1-17-25

PC 645 (9/12) LETTERS OF CONSERVATORSHIP

PE

MCL 700.5412, MCL 700.5417, MCL 700.5418, MCL 700.5423, MCL 700.5427,
MCR 5.202, MCR 5.203, MCR 5.205, MCR 5.409