Michigan Department of Community Health

MDCH

Rick Snyder, Governor
Nick Lyon, Director

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

CONSENT TO SHARE YOUR HEALTH INFORMATION

THIS FORM CANNOT BE USED FOR A RELEASE OF INFORMATION FROM ANY PERSON OR AGENCY THAT HAS PROVIDED SERVICES FOR DOMESTIC VIOLENCE, SEXUAL ASSAULT OR STALKING. A SEPARATE CONSENT MUST BE COMPLETED WITH THE PERSON OR AGENCY THAT PROVIDED THOSE SERVICES. (See FAQ at www.michigan.gov/bhconsent to determine if this restriction applies to you or your agency)

Individual's Name: ______________________ **Date of Birth:** __________

Individual's ID Number (Medicaid ID, SSN, other): ______________________

Your consent is needed to share certain types of your health information including:

- Behavioral and mental health services
- Referrals and treatment for alcohol and substance use disorder
- Communicable diseases such as sexually transmitted diseases and human immunodeficiency virus (HIV Infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex)

This information will be shared to help diagnose, treat, manage and get payment for your health needs. You can consent to share all of this information or just some information. (See FAQ at www.michigan.gov/bhconsent)

I. I consent to share my information among:

(Additional persons or agencies can be added at top of the next page)

1. ______________________ 3. ______________________

2. ______________________ 4. ______________________

II. I consent to share:

☐ All of my health information listed above

-OR-

☐ All of my information listed above except:
(list types of health information you do not want to share)

____

III. By signing this form I understand:

- My information may be shared among each agency and person listed above
- My information will be shared to help diagnose, treat, manage and pay for my health needs
- My consent is voluntary and will not affect my ability to obtain mental health or medical treatment, payment for medical treatment , health insurance or benefits
- My health information may be shared electronically
- This form does not affect the sharing of my physical health information for purposes of treatment, payment, or health care operations or as otherwise allowed by law
- The sharing of my health information will follow state and federal laws and regulations
- This form does not give my consent to share psychotherapy notes as defined by federal law
- I can withdraw my consent at any time; however any information shared with or in reliance upon my consent cannot be taken back
- I should tell all agencies and people listed on this form when I withdraw my consent
- I can have a copy of this form

My consent will expire on the following date, event or condition unless I withdraw my consent.
(If expiration date is left blank or is longer than one year, the consent will expire 1 year from the signature date)

____

I have read this form or have had it read to me in a language I can understand. I have had my questions about this form answered.

____
Signature of person giving consent or legal representative Date

Relationship to Individual

☐ Self ☐ Parent ☐ Guardian ☐ Authorized Representative

Additional persons or agencies – continued from previous page

5. ____________________ 8. ____________________

6. ____________________ 9. ____________________

7. ____________________ 10. ____________________

WITHDRAW OF CONSENT

I understand that any information already shared with or in reliance upon my consent cannot be taken back.

I withdraw my consent to the sharing of my health information:

☐ Between any of the following persons or agencies:

____________________ ____________________

____________________ ____________________

____________________ ____________________

-OR-

☐ For all persons and agencies

____
Signature of person withdrawing consent or legal representative Date

Relationship to Individual

☐ Self ☐ Parent ☐ Guardian ☐ Authorized Representative

Verbal Withdraw of Consent:

This consent was verbally withdrawn.

____
Signature of person receiving verbal withdraw of consent Date

☐ Individual provided copy ☐ Individual declined copy

AUTHORITY: This form is acceptable to the Michigan Department of Community Health as compliant with HIPAA privacy regulations, 45CFR Parts 160 and 164 as modified August 14, 2002, 42 CFR Part 2, PA 258 of 1974 and MCL 330.1748 and PA 368 of 1978, MCL 333.1101 et seq and PA 129 of 2014, MCL 330.1141a.

COMPLETION: Is Voluntary, but required if disclosure is requested.

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