

CONSENT TO SHARE BEHAVIORAL HEALTH INFORMATION

Michigan Department of Health and Human Services

Use this form to give or take away your consent to share information about your:

- Mental and behavioral health services. This will be referred to as “behavioral health” throughout this form.
- Diagnosis, referral and treatment for an alcohol or substance use disorder. This will be referred to as “substance use disorder” throughout this form.

This information will be shared to help diagnose, treat, manage and pay for health needs.

Why This Form Is Needed

When you receive health care, your health care provider and health plan keep records about your health and the services you receive. This information becomes a part of your medical record. Under state and federal laws, your health care provider and health plan do not need your consent to share most types of your health information to treat you, coordinate your care or get paid for your care. But they may need your consent to share your behavioral health or substance use disorder records.

Instructions

- To **give** consent, fill out Sections 1, 2, 3 and 4.
- To **take** away consent, fill out Section 5.
- Sign the completed form, then give it to your health care provider. They can make a copy for you.

Section 1: About You

First Name	Middle Initial	Last Name	Date of Birth	Date Signed

Section 2: Who Can See Your Information and How Can They Share It

Section 2a: Sharing Information Between Individual and Organizations

Let us know who can see and share your behavioral health and substance use disorder records. You should list the specific names of health care providers, health plans, family member or others. They can only share your records with people or organizations listed below.

1. _____	13. _____
2. _____	14. _____
3. _____	15. _____
4. _____	16. _____
5. _____	17. _____
6. _____	18. _____
7. _____	19. _____
8. _____	20. _____
9. _____	21. _____
10. _____	22. _____
11. _____	23. _____
12. _____	24. _____

First Name	Middle Initial	Last Name	Date of Birth	Date Signed

Section 2b: Sharing Information Electronically

Health information exchanges or networks share records back and forth electronically. This type of sharing helps the people involved in your health care. It helps them provide better, faster, safer and more complete care for you. Your health care provider and health plan may have already listed these organizations below.

Choose only one option:

- Share my information through the organizations listed below. This information will be shared with individuals and organizations listed under Section 2a.
- Do not share my information through the organizations listed below.
- Share my information through the organizations listed below with all of my past, current and future treating providers. If I choose this option, I can request a list of providers who have seen my records.

For Health Care Provider or Health Plan Use Only

List all health information exchanges or networks:

- | | |
|--|----------|
| 1. <u>MiHIN (MiHealth Information Network)</u> | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Section 3: What Information You Want to Share

Choose one option:

- Share **all** my behavioral health and substance use disorder records. This does not include “psychotherapy notes”.
- Share **only** the types of behavioral health and substance use disorder records listed below. For example, what I am being treated for, my medications, lab results, etc.

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Section 4: Your Consent and Signature

Read the statements below, then sign and date the form.

By signing this form below, I understand:

- I am giving consent to share my behavioral health and substance use disorder records. This includes referrals and service for alcohol and substance use disorders, but other information may also be shared.
- I do not have to fill out this form. If I do not fill out, I can still get treatment, health insurance or benefits. But, without this form, my provider or health plan may not have all the information needed to treat me.
- My records listed above in Section 3 will be shared to help diagnose, treat, manage and pay for my health needs.
- My records may be shared with the people or organizations as stated in Section 2.
- Other types of my health information may be shared along with my behavioral health and substance abuse use disorder records. Under existing laws, my health care provider and health plan do not need my consent to share most types of my health information to treat me, coordinate my care or get paid for care.
- This form does not give my consent to share “psychotherapy notes”.

First Name	Middle Initial	Last Name	Date of Birth	Date Signed

- I can remove my consent to share behavioral health and substance use disorder records at any time. I understand that any records already shared because of past approval cannot be taken back. I should tell all individuals and organizations listed on this form if I remove my consent.
- I have read this form or it has been read to me in a language I can understand. My questions about this form have been answered. I can have a copy of this form.
- This signature is good for **1 year** from the date signed or I can choose an earlier date or have it end after the event or condition listed below (for example, at the end of my treatment).

Date, event or condition: _____

State your relationship to the person giving consent and then sign and date below:

- Self
- Parent (print name) _____
- Guardian (print name) _____
- Authorized Representative (print name) _____

Signature	Date
Witness Signature (print name)	Date

TAKE AWAY YOUR CONSENT

Complete Section 5 if you no longer want to share your records listed above in Section 3.

Section 5: Who Can No Longer See Your Information

I no longer want to share my records those listed in Section 2a and 2b. I understand that any information already shared because of past approval cannot be taken back.

State your relationship to the person giving consent and then sign and date below:

- Self
- Parent (print name) _____
- Guardian (print name) _____
- Authorized Representative (print name) _____

Signature	Date
Witness Signature (print name)	Date

First Name	Middle Initial	Last Name	Date of Birth	Date Signed

FOR HEALTH CARE PROVIDER OR HEALTH PLAN USE ONLY

Verbal Withdraw of Consent

The individual listed above in Section 1 has taken away his/her consent.

List the individual who requested the withdrawal below, then sign and date below.

Individual listed above in Section 1.

Parent (print name) _____

Guardian (print name) _____

Authorized Representative (print name) _____

Signature

Date

Other Information for Health Care Providers and Health Plans

This form cannot be used for a release of information from any person or agency that has provided services for domestic violence, sexual assault, stalking or other crimes. See the FAQ for providers and organizations at michigan.gov/bhconsent.

Additional Identifiers (optional)

Medicaid

Last 4 of the Social Security Number

Form Copy (optional, choose one option)

The individual in Section 1 **received** a copy of this form.

The individual in Section 1 **declined** a copy of this form.

AUTHORITY:	This form is acceptable to the Michigan Department of Health and Human Services as compliant with 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.
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COMPLETION:	Is voluntary but required if disclosure is requested.
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