AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Michigan Department of Health and Human Services

Directions: *Type or Print all requested information, with exception of signatures on Page 2.*

Individual's Name (Beneficiary, Recipient, Patient, Consumer, etc.)			Individual's ID Number (Medicaid, SSN, Other)
Street Address			Individual's Date of Birth / /
City	State I	ZIP Code	Phone ( ) -

I AUTHORIZE THE MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES (MDHHS) TO SHARE MY HEALTH INFORMATION:

List the amount or type of information you would like to share in the section below.
For example, you can say all my health information or list certain types of information you would like to share.

ALL HEALTH INFORMATION

MDHHS MAY SHARE MY HEALTH INFORMATION WITH THE FOLLOWING PERSON OR ORGANIZATION:

Name of Person/Organization

Street Address

City, State, ZIP Code

( ) - ( ) -

Phone Number Fax Number

MDHHS WILL SHARE MY HEALTH INFORMATION FOR THE FOLLOWING REASON:

For example, to discuss my health care benefits or at the request of the individual.

AT THE REQUEST OF THE INDIVIDUAL

BY SIGNING THIS FORM, I UNDERSTAND THAT:

- I do not have to sign this authorization.
- My refusal to sign this authorization will not affect my ability to obtain treatment, payment for services, enrollment or eligibility for benefits.
- **Information regarding behavioral and mental health services, substance use disorder treatments, and communicable diseases such as sexually transmitted diseases and human immunodeficiency virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS related complex) may be shared if I initial here or if I list this type of information above _____.**
- If I authorize the release of substance use disorder treatment information, the recipient cannot re-disclose this information without my permission unless permitted under federal or state law.
- Other types of information shared under this authorization may be re-disclosed by the person or organization I identified above and may no longer be protected by federal or state law.
- I may change my mind and revoke (take back) this authorization at any time. To revoke this authorization, write to the MDHHS program that maintains your records and include a copy of the front of this form.
- Information that has already been shared based on this authorization cannot be taken back.
- I may request a copy of this signed authorization. If I have not previously revoked this authorization, it will expire on: *(list a date, event or condition)*

UNTIL NO LONGER ENROLLED IN CSHCS

Date, Event or Condition
(Authorization will expire one year from the signature date if you leave this section blank.)

Signature of Individual or Legal Representative	Date / /
Name of Individual or Legal Representative	
Legal Representative's Relationship to Individual (i.e., Parent, Guardian, Patient Advocate, Authorized Representative, Power of Attorney. Documentation may be required.)	

MDHHS USE ONLY

This authorization was revoked:

/ /

Signature Date

AUTHORITY: This form is acceptable to the Michigan Department of Health and Human Services as compliant with HIPAA privacy regulations, 45CFR Parts 160 and 164 as modified August 14, 2002.

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

Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs, or disability.