Health Department

FAX RECORDS TO: (586) 466-4153

AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION FOR CARE COORDINATION

Children's Special Health Care Services

Completion of this form authorizes 2-way communication between the Macomb County Health Department (MCHD) and an outside provider, organization or facility to share my information so care coordination services can be provided.

ALL 5 SECTIONS MUST BE COMPLETED FOR THIS AUTHORIZATION TO BE VALID. INCOMPLETE FORMS WILL NOT BE HONORED.

SECTION 1: PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: ___ Date of Birth: _____

Address: _____ County: _____

Parent/Guardian Name: _____

Phone Number: _____ CSHCS/Medicaid ID Number: _____

SECTION 2: NAME OF OUTSIDE PROVIDER, ORGANIZATION OR FACILITY

Name of outside provider, organization or facility: _____

Address: _____

Phone Number: _____

SECTION 3: INFORMATION TO DISCLOSE/RELEASE & PURPOSE FOR DISCLOSING/SHARING INFORMATION:

Date of Information Requested: ***Most recent medical records - from past 12 months*** Reason: **Coordination of Care**

SECTION 4: WHO SHOULD RECEIVE THE INFORMATION?

Name: Macomb County Health Department (MCHD) / Children's Special Health Care Services (CSHCS)

Address: 25401 Harper Ave., St. Clair Shores, MI 48081 **Phone Number: (586) 466-6855** **Fax Number: (586) 466-4153**

SECTION 5: SIGNATURE & AUTHORIZATION EXPIRATION DATE:

- The organization listed in Section 2 may disclose my protected health information (PHI) for my care coordination.
- Unless revoked, this authorization expires 12 months from the date signed.
- I have the right to end (i.e. revoke) this authorization by notifying the health department program (that is sharing the information to coordinate my services) of my request in writing.
- If I make a request to end this authorization, it will not include information that has already been disclosed based on my previous permission.
- My refusal to sign this authorization will not affect my ability to obtain treatment, payment for services, enrollment or eligibility for benefits.
- I may request a copy of this signed authorization.
- If I choose not to agree with this request, my benefits or services will not be affected.
- I understand that this information is protected by Federal and state laws and cannot be disclosed without my consent unless otherwise provided in the regulations
- These records may include any information about behavioral and mental health services, substance use disorder treatments, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC); any other communicable diseases as defined by MDHHS.

_____

Signature of Patient or Legal Guardian

_____

Date (MM/DD/YYYY)

_____

Print Name of Patient or Legal Guardian

Date Received:_____
Receive By MCHD Employee #: _____

MCHD USE ONLY

Entered in M&M (VHN): ☐ YES ☐ NO
M&M Medical Record #: _____