Southwest Michigan
BEHAVIORAL HEALTH

Section: **Compliance**	Policy Name: **Use of MDHHS Standard Consent Form (MDHHS-5515)**	Policy Number: **10.21**
Owner: **Chief Compliance Officer**	Reviewed By: **Mila C. Todd**	Total Pages: **3**
Required By: ☐ **BBA** ☒ **MDHHS** ☐ **NCQA** ☐ **Other (please specify):** _____	Final Approval By: Mila C. Todd Mila Todd (Mar 31, 2023 05:12 EDT)	Date Approved: Mar 31, 2023
Application: ☒ **SWMBH Staff/Ops** ☒ **Participant CMHSPs** ☒ **SUD Providers** ☒ **MH/IDD Providers** ☒ **Other (please specify):** **MI Health Link**	Line of Business: ☒ **Medicaid** ☒ **Healthy Michigan** ☒ **SUD Block Grant** ☒ **SUD Medicaid** ☒ **MI Health Link** ☐ **Other (please specify):** _____	Effective Date: **10-01-2015**

Policy: Southwest Michigan Behavioral Health (SWMBH) will not use or disclose protected health information (PHI) without written authorization except where permitted or required by state and/or federal law(s). In obtaining written authorization for the disclosure of confidential mental health and substance use disorder information for use by all public and private agencies, departments, corporations, or individuals that are involved with treatment of an individual experiencing serious mental illness, serious emotional disturbance, developmental disability, or substance use disorder, SWMBH and its provider network shall honor, accept and use MDHHS-5515, "Permission to Share Behavioral Health Information" (hereafter referred to as "Standard Consent Form"), for the electronic and non-electronic sharing of all behavioral health and SUD information, in accordance with PA 129 of 2014, MCL 330.1141a. No other consent forms may be used for such treatment-related disclosures.

When obtaining written authorization for disclosures that do not fall under a Health Insurance Portability and Accountability Act (HIPAA) exception, a HIPAA compliant consent form shall be used.

The Standard Consent Form must not 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 form must be completed with the person or agency that provided those services.

SWMBH recognizes that a Consent Form is not required for all disclosures, where an exception is provided by law.

Purpose: Southwest Michigan Behavioral Health (SWMBH) collects and maintains member protected health information (PHI) that includes personal identifiers, enrollment, eligibility, treatment, and dependent and qualifying event information.

SWMBH is obligated to protect the privacy of PHI in accordance with all applicable State and Federal laws, as well as internal policies and procedures related to privacy and security of PHI. Michigan Public Act 129 of 2014 mandated that the Michigan Department of Health and Human Services (MDHHS) develop a standard release form for exchanging and sharing confidential mental health and substance use disorder information for use by public and private agencies, departments, corporations, or individuals that are involved with treatment of an individual experiencing serious mental illness, serious emotional disturbance, developmental disability, or substance use disorder (form MDHHS-5515). Schedule A, Section (1)(N)(8) of SWMBH's Prepaid Inpatient Health Plan (PIHP) Contract with MDHHS mandates that SWMBH and its provider network use, accept, and honor the standard release form for the electronic and non-electronic sharing of all behavioral health and substance use disorder (SUD) PHI.

Scope: SWMBH and its provider network

Responsibilities:

SWMBH and its entire provider network are required to accept, use, and honor the MDHHS Standard Consent Form (MDHHS 5515) for treatment related disclosures when a release of information is required.

Upon securing the MDHHS Standard Consent Form (MDHHS 5515) from an individual, SWMBH and its provider network must ensure the individual is offered a copy of the signed MDHHS 5515 and document whether the individual received or declined a copy. MDHHS 5515 provides for this documentation in the "Form Copy" box of the form.

Definitions:

A. **Protected Health Information (PHI)** – has the meaning given such term in section 160.103 of title 45, Code of Federal Regulations.

Standards and Guidelines: None.

References: PA 129 of 2014, MCL 330.1141a; 45 CFR §164.508

Attachments: MDHHS 5515

Revision History

Southwest Michigan
BEHAVIORAL HEALTH

Revision #	Revision Date	Revision Location	Revision Summary	Revisor
01	7/01/2020	N/A	Moved to new template	Mila C. Todd
02	7/01/2020	Last sentence of "Policy" Section.	Recognizing Releases are not required where there is an exception provided for by law.	Mila C. Todd
03	12/22/2022	Purpose	Annual Review. Updated MDHHS-PIHP Master Contract reference	Mila C. Todd
04	03/06/2023	Responsibilities	Added requirement for offering members a copy of the form.	Mila C. Todd

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Final Audit Report 2023-03-31

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"10.21 Use of MDHHS Standard Consent Form (MDHHS 5515)" History

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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 your 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 Sections 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 They Can Share It

Section 2a: Sharing Information Between Individuals 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 members, or others. They can only share your records with people or organizations listed below.

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

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 the 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. _____ 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 services 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 it 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 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".
- 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 (If Appropriate)	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 with those listed in Sections 2a and 2b. I understand any information already shared because of past approval cannot be taken back.

State your relationship to the person withdrawing consent, then sign and date below.

☐ Self

☐ Parent (Print Name) _____

☐ Guardian (Print Name) _____

☐ Authorized Representative (Print Name) _____

Signature	Date
Witness Signature (If Appropriate)	Date

FOR HEALTH CARE PROVIDER OR HEALTH PLAN USE ONLY

Verbal Withdrawal 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 of Person Who Received the Verbal Withdrawal	Print Name	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 other 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.
COMPLETION:	Is Voluntary, but required if disclosure is requested.

The 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.