

## CONSENT TO SHARE BEHAVIORAL HEALTH INFORMATION FOR CARE COORDINATION PURPOSES

Michigan Department of Health and Human Services

**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 form must be completed with the person or agency that provided those services.** (See FAQ at [www.michigan.gov/bhconsent](http://www.michigan.gov/bhconsent) to determine if this restriction applies to you or your agency.)

First Name	Middle Initial	Last Name	Date of Birth	Individual's ID Number (Medicaid ID, Last 4 digits of SSN, other)
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Under the Health Insurance Portability and Accountability Act (HIPAA), a health care provider or agency can use and share most of your health information in order to provide you with treatment, receive payment for your care, and manage and coordinate your care. However, your consent is needed to share certain types of health information. This form allows you to provide consent to share the following types of information.

- Behavioral and mental health services
- Referrals and treatment for an alcohol or substance abuse disorder

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](http://www.michigan.gov/bhconsent))

**I. I consent to share my information among:**

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |

**II. I consent to share:**

- All of my behavioral health and substance use disorder information
- All of my behavioral health and substance use disorder information except: (List types of health information you do not want to share below)
- \_\_\_\_\_

I understand that HIPAA allows providers and other agencies to use and share much of my health information without my consent in order to provide me with treatment, receive payment for my care, and to manage and coordinate my care.

**III. By signing this form I understand:**

- I am giving consent to share my behavioral health and substance use disorder information. Behavioral health and substance use disorder information includes, but is not limited to, referrals and services for alcohol and substance use disorders.
- 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.
- Other types of my information may be shared with my behavioral health and substance use disorder information. HIPAA allows my providers and other agencies to use and share most of my health information without my consent in order to provide me with treatment, receive payment for my care, and to manage and coordinate my care.
- 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.)

Expiration 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
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Relationship to individual  
 Self                       Parent                       Guardian                       Authorized Representative

**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 giving 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 Health and Human Services as compliant with HIPAA privacy regulations, 45 CFR 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.

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.