

# CONSENT TO SHARE BEHAVIORAL HEALTH INFORMATION FOR CARE COORDINATION PURPOSES

Michigan Department of Health and Human Services

**Providers or agencies receiving funding under the Violence Against Women Act, the Family Violence Prevention and Services Act, and the Victim of Crimes Act may not use this form. This form should be used with caution by other providers or organizations serving individuals with heightened safety and privacy concerns due to experiences with domestic violence, sexual assault, stalking, or other crimes. If use of this form is not appropriate, a separate consent form must be completed with the person or agency who provided 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 | Zip Code | Individual's ID Number (e.g. Medicaid ID) |
|------------|----------------|-----------|---------------|----------|---|

Under the Health Insurance Portability and Accountability Act (HIPAA) and the Michigan Mental Health Code, a health care provider or agency can use and share most of your health information in order to provide you with treatment, coordinate your care, or receive payment for your care. However, your consent is needed to share other types of health information or for other reasons. You can give permission to share the following types of information with this form:

- Behavioral and mental health services (for reasons other than for treatment, payment, or coordination of care)
- Referrals and treatment for an alcohol or substance use disorder (e.g. drug test results, labs, claim history)

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)).

## SECTION 1: TO WHOM AND FROM WHOM

A. I consent to allow the following individuals and/or organizations to send and receive my information. (Please list the specific providers that may send or receive your information. You may include providers, third-party payers, family members, or other individuals and organizations.)

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

B. I consent for the following organizations that help transmit my information through electronic exchange of health information (e.g. Health Information Exchange, Health Information Organization, Health Information Network, etc.) to receive and re-disclose my health records.

|                                  |                                  |
|----------------------------------|----------------------------------|
| 1. _____<br>2. _____<br>3. _____ | 4. _____<br>5. _____<br>6. _____ |
|----------------------------------|----------------------------------|

C. By checking the box below, I consent to allow organizations that are listed under sub-section B to share my information with all of my past, current, and future treating providers who are members of the electronic exchange organization.

All of my past, current, and future treating providers.

#### ADMINISTRATIVE USE ONLY

Check this box if the individual has withdrawn their consent under Section 4. If this box is checked, behavioral health and substance use disorder information should not be shared with individuals and organizations that are listed on this form unless the sharing of this information is otherwise authorized under state and federal law.

### SECTION 2: AMOUNT AND KIND

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).

Only the following records: (List types of health information you do want to share below).

I understand that HIPAA and the Michigan Mental Health Code 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 coordinate my care.

### SECTION 3: OTHER IMPORTANT INFORMATION

By signing this form, I understand:

- I am giving consent to share my behavioral health and substance use disorder information as indicated in Sections 1 and 2. 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 individual and organization listed in Section 1.
- 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 treatment, payment for treatment, and 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 and the Michigan Mental Health Code 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 coordinate my care.

• This form allows me to choose to share my health information with past, current, and future treating providers under Sub-Section 1c. If I agree to share my health information in this way, I can request a list of all of the individuals and organizations who received my health information within the last two years. I must make this request to the organization(s) under Sub-Section B in writing. I can ask my provider for assistance if I am not sure how to contact the organization(s) under Sub-Section B.

- 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 or revoke my consent at any time. I understand that any information previously shared with or in reliance upon my consent cannot be taken back.
- I should tell all individuals and organizations 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 this field is left blank, the consent will expire 1 year from the signature date.)

Expiration Date, Event, or Condition:

\_\_\_\_\_

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   |
| Relationship to Individual                                 |  |
| <input type="checkbox"/> Self                              | <input type="checkbox"/> Parent                    |
| <input type="checkbox"/> Guardian                          | <input type="checkbox"/> Authorized Representative |

**SECTION 4: WITHDRAWAL OF CONSENT**

This section should only be completed if you are withdrawing consent to share your health information. 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.

|  |  |
|--|--|
| Signature of person giving consent or legal representative | Date   |
| Relationship to Individual                                 |  |
| <input type="checkbox"/> Self                              | <input type="checkbox"/> Parent                    |
| <input type="checkbox"/> Guardian                          | <input type="checkbox"/> Authorized Representative |

**VERBAL WITHDRAW OF CONSENT:**

This consent was verbally withdrawn.

|  |   |
|--|---|
| Signature of person giving consent or legal representative | Date  |
| <input type="checkbox"/> Individual provided copy          | <input type="checkbox"/> Individual declined copy |

|                    |   |
|--------------------|---|
| <b>AUTHORITY:</b>  | 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. |
| <b>COMPLETION:</b> | 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.