CONSENT TO SHARE BEHAVIORAL HEALTH INFORMATION FOR CARE COORDINATION PURPOSES

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

Individual's Name	Date of Birth	Individual's ID Number (Medicaid ID, Last 4 digits of SSN, other)

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 for Upper Great Lakes Family Health Center to share the following types of information:

- Behavioral and mental health services
- Referrals and treatment for alcohol and substance use 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)

I. I authorize the below Persons/Organization to receive/provide information either ☐ Document ☐ Verbally ☐ Both

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

II. I consent to share:

☐ All of my behavioral health and substance disorder information

☐ All of my behavioral health and substance use disorder information except:
(List types of health information you so not want to share below)

_____

_____

OR

☐ Release records only in emergency situations

I understand the 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. Behavior 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. The law 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 defines by federal law.
- By checking each item below I agree to share this information with the Persons/Organizations listed above.

( ) Substance Abuse Assessment
( ) Mental Health/Psychosocial Assessment
( ) Anger Management Assessment
( ) Sex Offender Assessment & Test Summary
( ) Psychological Evaluation
( ) Emergency Contact
( ) Verbal Communication
( ) Other_____

( ) Urine/PBT reports
( ) Attendance
( ) Treatment Plans
( ) Aftercare Plan
( ) Discharge Summary
( ) Progress in treatment
( ) Medical Information
( ) All

- 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.)

_____

Patient Initials _____

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 ☐ Self ☐ Parent ☐ Guardian ☐ Authorized Representative	
Witness Print Name:	Signature:

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:

_____ _____

_____ _____

_____ _____

☐ 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