CONSENT TO DISCLOSE BEHAVIORAL HEALTH OR SUBSTANCE USE INFORMATION

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	Medical Record Number

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 (UGLFHC) 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 UGLFHC to disclose the information noted in section III to the following Individuals:

NAME		PHONE		☐ Documents	☐ Verbally	☐ Both
NAME		PHONE		☐ Documents	☐ Verbally	☐ Both
NAME		PHONE		☐ Documents	☐ Verbally	☐ Both

II. I authorize UGLFHC to release my records to the following:

Name		Address	
Phone #		Fax #	
Encrypted email			
Purpose of this Request			
☐ Personal Use	☐ Relocating	☐ Transferring to another provider	
☐ Continuation/Coordination of Care	☐ Disability	☐ Legal	
☐ Insurance	☐ Other		

III. I consent to share: **☐ONE TIME ONLY** **☐ONGOING**

☐	Substance Abuse Assessment	☐	Drug Screen Reports
☐	Mental Health/Psychosocial Assessment	☐	Treatment Plans
☐	Anger Management Assessment	☐	Discharge Summary
☐	Sex Offender Assessment & Test Summary	☐	Progress in Treatment
☐	Psychological Evaluation	☐	All Substance Use Treatment Records
☐	All Behavioral Health Records	☐	Emergency Contact Name and Contact Information
☐	All Records	☐	Attendance Records
☐	Release only what is needed in an Emergency	☐	Other:

IV. By signing this form, I understand:

- This is good for one (1) year from the date on this form **UNLESS** the one-time release box has been checked
- I am giving consent to share my behavioral health and substance use disorder information.
- 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 Provider. 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.
- 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.

I have read this form or have had it read to me in a language I can understand. I have had my q
answered.

Signature of person giving consent or legal representative	Printed Name	Date
Relationship to individual ☐ Self ☐ Parent ☐ Guardian ☐ Authorized Representative		
Witness Print Name:	Signature:	

☐ Individual provided copy ☐ Individual declined copy