Region 10 PIHP

Authorization for Release of Record Information Form

IDENTIFYING INFORMATION

☐ Guardian ☐ Parent of Child ☐ Authorized Representative ☐ Other:_____

NAME OF REQUESTOR:	PHONE NUMBER:
ADDRESS:	

I hereby authorize Region 10 PIHP to release information regarding:

NAME OF CONSUMER:	PHONE NUMBER:
ADDRESS:	DOB:

Information requested to be released to:

NAME: Legal-Ease Digital Imaging	PHONE NUMBER: 855-534-4003
ADDRESS: 2496 Meadowcroft Dr Burton, MI 48519	

**If the information requested is to be released to someone other than the Consumer, Guardian, Parent of Child, or Authorized Representative, a Consent to Share Behavioral Health Information form (MDHHS-5515 form) will need to be completed in addition to this form.*

SPECIFIC INFORMATION REQUESTED

_____

_____

_____

_____

_____

_____

☐ Check here if the specific information is related to alcohol, drugs of abuse and / or other drugs, drug testing results being shared between primary care physician and PIHP.

PURPOSE OR NEED FOR REQUEST

☐ Coordination of Benefits ☐ Coordination of Services / Care ☑ Legal

☐ Consumer Request ☐ Billing / Payment

- I understand that if the person(s) or organization(s) that receives the information is not a health care provider or health care plan covered by Federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.
- I understand that I may refuse to sign this authorization and that generally my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits. When the exchange of personal health information (PHI) is specifically related to alcohol, drugs of abuse and/other drugs, or drug testing results, my treatment may be conditioned because my refusal to release the results could compromise my safety and the availability of medication appropriate for my treatment.
- I understand that I may inspect and/or obtain a copy of any information used / disclosed under this authorization.
- I understand that these records may include information regarding mental health treatment, and/or alcohol or substance use, and/or information regarding HIV, AIDS, or the status of other communicable diseases.
- I understand this authorization will expire / not exceed 1 year, I further understand that I may revoke this authorization at any time by notifying the PIHP in writing, but I understand that previously disclosed information would not be subject to my revocation request.

SIGNATURES

PRINTED NAME	CONSUMER SIGNATURE	DATE
PRINTED NAME	REQUESTOR SIGNATURE	DATE

Updated: 6/1/2021

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. Legal-Ease Digital Imaging P.O. Box 1017 Flint MI 48501 855-534-4003
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:

- [x] 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:

- [x] 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.