MDHHS-5515, CONSENT TO SHARE BEHAVIORAL HEALTH INFORMATION

Michigan Department of Health and Human Services (MDHHS)
(Revised 9-25)

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.

If using this form for multiple party disclosures, all information identified will be shared with all parties identified on this form. If this is not the goal, use separate forms.

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, and then fill out either section 2 Treatment, Payment, and Healthcare Operations (TPO) only, sections 3 and 4 only or sections 2, 3 and 4.

This consent will not be used for any civil, criminal, administrative, or legislative proceedings.

To take away consent, fill out Section 6.

Sign the completed form, then give it your health care provider. They can make a copy for you.

SECTION 1 - ABOUT YOU

Name (First, Middle Initial and Last) Date of Birth

SECTION 2 - TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS (TPO)

Sharing information between individuals and organizations

Consent for All Future Uses for Treatment, Payment, and Health Care Operations

☒ Share all behavioral health and substance use disorder information with all my treating providers, health plans, third-party payers, and people helping to operate this program for treatment, payment, and health care operations.

Expiration for TPO consent: Unless otherwise specified below, this consent does not expire.

☐ This consent expires (optional)

When providing a consent for treatment, payment, and health care operations there is the potential for the records used or disclosed pursuant to the consent to be subject to redisclosure by the recipient and no longer protected by 42 CFR Part 2.

If you do not consent to sharing for treatment, payment, and health care operations the consequences, if any; are **Billing and record keeping are affected.**

SECTION 3 - WHO CAN SEE YOUR INFORMATION AND HOW THEY CAN SHARE IT

A. 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.

☒ Health Plan -	☒ Pre-paid Inpatient Health Plan (PIHP) - HealthWest
1. My medical insurance company	2. Muskegon Family Care
3. Primary Care Provider	4.
5.	6.

B. 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:

☐ Share my information through the organizations listed below. This information will be shared (not shared) with the individuals and organizations listed under Section 3a.

☐ 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. Trinity Health	2. MIHIN
3.	4.
5.	6.

SECTION 4 - WHAT INFORMATION YOU WANT TO SHARE

Choose one option:

☐ Share all my behavioral health and substance use disorder records. This does not include "psychotherapy notes and/or substance use disorder counseling notes."

☐ Share only the types of behavioral health and/or substance use disorder records listed above. For example, what I am being treated for, my medications, lab results, etc.

Types of Records

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

The expiration date, event, or condition for Sections 3 and 4:

This signature is good for one year from the date signed. I can choose an earlier date to terminate this consent or have it end after the event or condition listed below.

Date, event, or condition

SECTION 5 - 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/or substance use disorder records. This includes referrals and services for alcohol and substance use disorders and/or other information may also be shared.
- My records may be shared with the people or organizations as described above.
- 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 and/or with substance use disorder counseling 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.

State your relationship to the person giving consent then sign and date.

☐ Self

☐ Parent (print name)

☐ Guardian (print name)

☐ Authorized Representative (print name)

Signature →	Date

SECTION 6 - TAKE AWAY YOUR CONSENT, WHO CAN NO LONGER SEE YOUR INFORMATION

I no longer want to share my records with those listed above. 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.

☐ Self

☐ Parent (print name)

☐ Guardian (print name)

☐ Authorized Representative (print name)

Signature →	Date

SECTION 7 - FOR HEALTH CARE PROVIDER OR HEALTH PLAN USE ONLY

Verbal Withdrawal of Consent

List the individual who requested the withdrawal below, then sign and date.

☐ The individual listed in Section 1.

☐ Parent (print name)

☐ Guardian (print name)

☐ Authorized Representative (print name)

Print name of person who received the verbal withdrawal

Signature →	Date

Other Information for Health Care Providers and Health Plans

This form cannot be used for a release of information for 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 www.michigan.gov/bhconsent.

Additional Identifiers (optional)

Medicaid ID Number

Last four digits of Social Security Number

Form Copy (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.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

AUTHORITY: This form is acceptable to MDHHS 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: Voluntary but required of disclosure is requested.

Muskegon Family Care

AUTHORIZATION FOR RELEASE OF INFORMATION

Name:	Date of Birth:	Client ID:

To Whom and From Whom:

I, _____ today's Date, _____

Authorize: Muskegon Family Care of 2201 S. Getty, Muskegon Heights, MI 49444

I consent (check one) ☐ release to ☐ obtain from ☐ exchange with the indicated facility/designee the following information: mental health treatment records; financial records, substance abuse; serious communicable disease or infection information (HIV/AIDS, tuberculosis and venereal diseases); and/or information obtained from other health care providers/agencies. (Client or parent/guardian may line through and initial above any information that is not to be authorized for release.)

Is this patient's Primary care Provider ☐ Yes ☐ No

Facility/Designee Name:				
Street	City	State	Zip	Phone

The following information:

☐ Both Medical/ Mental Health Treatment and Financial Records
☐ Medical/ Mental Health Treatment Records
☐ Financial Records
☐ substance abuse
☐ Other_____

Specific purpose for release ☐ Coordination of care ☐ Assistance with benefits ☐ Self ☐ Other_____
☐ Substance Abuse (Be as specific as possible; what kind of information)

_____

I understand that my alcohol and or/substance use treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patients Records, 42 Code of Federal Regulations (CFR) Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 CFR, Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically one year from today.

Patient Signature/Guardian _____ Date _____

Personal Representative for Deceased Client _____ Date _____

MFC Staff Signature _____ Date_____

Muskegon Family Care

Muskegon Family Care

AUTHORIZATION FOR RELEASE OF INFORMATION

EMERGENCY CONTACT ONLY

Name:	Date of Birth:	Client ID:

To Whom and From Whom:

I, _____ today's Date, _____

Authorize: Muskegon Family Care of 2201 S. Getty, Muskegon Heights, MI 49444

I consent (check one) ☐ release to ☐ obtain from ☐ exchange with the indicated facility/designee the following information: mental health treatment records; financial records, substance abuse; serious communicable disease or infection information (HIV/AIDS, tuberculosis and venereal diseases); and/or information obtained from other health care providers/agencies. (Client or parent/guardian may line through and initial above any information that is not to be authorized for release.)

Is this patient's Primary care Provider ☐ Yes ☐ No

Facility/Designee Name:				
Street	City	State	Zip	Phone

The following information:

☐ Both Medical/ Mental Health Treatment and Financial Records
☐ Medical/ Mental Health Treatment Records
☐ Financial Records
☐ substance abuse
☐ Other_____

Specific purpose for release ☐ Coordination of care ☐ Assistance with benefits ☐ Self ☐ Other_____
☐ Substance Abuse (Be as specific as possible; what kind of information)

_____

I understand that my alcohol and or/substance use treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patients Records, 42 Code of Federal Regulations (CFR) Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 CFR, Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically one year from today.

Patient Signature/Guardian _____ Date _____

Personal Representative for Deceased Client _____ Date _____

MFC Staff Signature _____ Date_____

Muskegon Family Care

CONSENT FOR PARTICIPATION IN DATA COLLECTION

Name:	Date of Birth:	Client ID:

To Whom and From Whom:

I, _____ today's Date, _____

☐Authorize: Muskegon Family Care of 2201 S. Getty, Muskegon Heights, MI 49444

To collect data from my medical, behavioral health and or substance use records during the course of my treatment and after discharge of any program within Muskegon Family Care. This would be for the purpose of reporting for quality assurance, grants, research, and program development, no names will ever be mentioned. All data will be given an ID, number in place of names.

If you decide you DO NOT want to participate in data collection this WILL NOT hinder you from participating in our Medication Assisted Treatment Program.

I, _____ today's Date, _____

☐DECLINE participation in any Data Collection and understand this will not be a barrier to treatment.

The following information:

☐ Both Medical/ Mental Health Treatment and Financial Records
☐ Medical/ Mental Health Treatment Records
☐ Financial Records
☐ substance abuse
☐ Other_____

Specific purpose for release: Data collection and reporting

I understand that my alcohol and or/substance use treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patients Records, 42 Code of Federal Regulations (CFR) Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically one year from today.

Patient Signature/Guardian _____ Date _____

MFC Staff Signature _____ Date_____