Western Wayne Family Health Centers
PHONE - (734) 941-4991
Medical Records FAX (313) 447-2455

Release of Health Information Authorization

I, _____ ☐☐☐-☐☐☐-☐☐☐☐
(Print Patient's Name) *(Patient's Telephone Number)*

_____
(Patient address)

I authorize:

Western Wayne Family Health Centers

OFFICE (734) 941-4991
FAX: (313) 447-2455

To release information contained in my patient records, including applicable information about communicable diseases and infections, as defined by the state of Michigan Department of Consumer & Industry Services (NDCIS) which include venereal disease "VD", tuberculosis "TB" , human immunodeficiency syndrome "AIDS", and AIDS related complex "ARC", alcohol and drug abuse treatment information protected under the regulation in 42Code of Federal Regulations, Part 2, psychological services and social services information including communication made by me to a social worker or psychologist, to the individual or organizations listed, only under the conditions listed below:

1. **Name and address of receiver of Information:** RECORDS DEPOSITION SERVICE
PO BOX 5054, SOUTHFIELD, MI 48086-5054

PHONE: 248-357-3330 **FAX:** 248-357-3337

2. **Specific type of information to be disclosed, include date(s) of service:** _____

3. **The purpose and need for such disclosure:** ☐ **CONTINUITY OF CARE** ☒ **OTHER**

4. I understand that I have a right to revoke this authorization at any time except noted below. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the appropriate department/facility that was authorized to release information. I understand that the revocation will not apply to information that has already been released in response to this authorization or where the WWFHC has acted in reliance upon this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. The right to revoke is also discussed in the WWFHC Privacy Notice.

Unless otherwise revoked, this authorization will expire upon the occurrence of the following event:

☐ **UPON COMPLETION OF REQUEST** ☐ **1 YEAR FROM AUTHORIZATION DATE**

5. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. However, my request to release information will not be fulfilled. I understand the Western Wayne Family Health Center will not refuse treatment if I do not sign this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may no longer be protected by federal and state confidentiality rule.

I represent that I am the patient or an Authorized representative of the patient as that term is defined in Michigan law regarding the release of medical records.

_____ _____
(Signature of Patient or Authorized Representative) **(Relationship to Patient)**

_____ ____/____/____ **Patient's DOB** ____/____/____

(Signature of Witness) **(Today's Date)** **Last 4 digits of Patient's SS#** ☐☐☐☐

NOTE: RECORDS REQUESTS TAKE 7-10 BUSINESS DAYS FOR PROCESSING, UNFORTUNATELY THIS TIME CANNOT BE EXPEDITED. PLEASE ALLOW SUFFICIENT TIME FOR THIS PROCESS.

(Rev. 06/2010)

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. RECORDS DEPOSITION SERVICE
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:

☒ 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.	RECORDS DEPOSITION SERVICE	4.	
2.		5.	
3.		6.	

Section 3: 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."

☐ 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.