

MATERNAL INFANT HEALTH PROGRAM

Authorization and Consent to Release Protected Health Information

The Michigan Department of Community Health, **Maternal Infant Health Program (MIHP)** is designed to provide you with information and referrals to agencies that may help you and your baby stay healthy and assist you with caring for yourself and your infant. To do this, **we would like you to answer some questions to help us understand** your daily living habits and to identify potential health risks to you and your infant.

The answers that you give to the questions are protected health information and will be kept confidential unless we are permitted or required by law to release them. In order to plan and provide the best possible care for you and your infant, we may need to share the answers that you give with various health and social services professionals and other community agencies. To assure that MIHP services are coordinated with your primary health care provider, we may also need to provide information regarding services you receive or need with your physician.

Your answers to the questions in this interview will assist MIHP staff to determine what, if any, services are appropriate for you. You may choose to not answer some questions or end the interview at any time and this will not affect your Medicaid eligibility. However, lack of information resulting from these actions may result in you not receiving services that might otherwise be available through this program.

- By signing this form, I authorize the (name of the MIHP agency) to disclose my health information.
- I understand that this information may include, when applicable, information relating to sexually transmitted diseases, Human Immunodeficiency Virus (HIV Infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex) and other communicable diseases. It may also include information about behavioral or mental health services, and referral and/or treatment for alcohol and drug abuse (as permitted by MCL 330.1748, P.A. 258 of 1974 and 42 CFR Part 2).
- I also understand that if I give permission, I have the right to change my mind and revoke it. I understand that if I choose to revoke my permission, I will give written notice to the (MIHP agency) that maintains my records. I understand that any uses or disclosures already made with my permission cannot be taken back.
- I understand that authorizing the disclosure of this health information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my Medicaid eligibility for benefits unless the information is necessary to demonstrate that I meet eligibility or enrollment criteria.
- By signing this authorization, I understand that any disclosure of information carries with it potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules. I further understand I may request a copy of this signed Authorization.
- Unless otherwise revoked, this authorization will expire at the end of MIHP services.

I have read the above or have had it read/explained to me. I agree to allow health information disclosure.

Signature of Beneficiary or Legal Representative

Date

I understand that I may qualify to receive MIHP services.

I **do not** wish to participate in the Maternal Infant Health Program.

I **do** wish to participate in the Maternal Infant Health Program.

Beneficiary Name (Print)

Legal Representative and Relationship to Beneficiary

Signature of Beneficiary or Legal Representative

Date

Signature of Interviewer (MIHP staff)

Date

AUTHORITY: This form is acceptable to the Michigan Department of Community Health as compliant with HIPAA privacy regulations, 45CFR Parts 160 and 164 as modified August 14, 2002.

COMPLETION: Is Voluntary, but required if disclosure is requested.

The Michigan Department of Community Health is an equal opportunity employer, services and programs provider.