

Maternal Infant Health Program
Michigan Department of Community Health
Consent to Release Protected Health Information

This form may be used in one of two ways

- 1. You secure the consent to release PHI form, which allows exchange of information regarding both the pregnant woman and any children –upon entry into MIHP as a pregnant woman.***
- 2. You secure 2 separate consents to release PHI. One when the pregnant woman enters the program and another when the infant(s) is born.***

Federal law protects your health information. This includes all information that MIHP collects, including:

1. Your Risk Identifier interview answers.
2. Other information you provide.
3. Information that another party provides.

You must consent before we can exchange information with any other party. We will keep your information in a confidential record.

We would like to be able to share the health information in our MIHP file with your health care provider. This is so we can give you and your infant the best possible care. We also may need to share information with other health and social services agencies. However, we will not share your health information without your consent. The only exception is when we are required by law to do so.

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1. I authorize the ***Your agency name must be here*** (MIHP agency) to exchange my family's health information to other parties as specified below:

- a. My health information may be exchanged with my health care provider:  
Yes No      Provider Name

***Check the appropriate box and write the name of the mother's medical provider (when securing the release of PHI for a pregnant woman).***

***When securing 2 separate releases—as noted in item 2 at the top of the page—it is recommended that you either***

- a. draw a line through this section when the consent to release is for new infant(s)***
- b. use this space to identify the baby's pediatrician (for discussion of maternal considerations) when the consent to release is for new infant(s)***

- b. My health information may be exchanged with the following parties:

| Name of provider or facility                                                                                                                                                                                                  | Date                                             | Initialed by Beneficiary                    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------|
| <i>Write the name of the provider or facility for exchange of PHI here. Typical contacts (i.e. DHS, WIC, Food banks, etc.) may be pretyped since the client's initials and date signifies that release of PHI is approved</i> | <i>The date of the initials is required here</i> | <i>Initials are required in this column</i> |
|                                                                                                                                                                                                                               |                                                  |                                             |
| <b>WIC</b>                                                                                                                                                                                                                    |                                                  |                                             |
| <b>DHS</b>                                                                                                                                                                                                                    |                                                  |                                             |
| <b>CMH</b>                                                                                                                                                                                                                    |                                                  |                                             |
| <b>Loaves and Fishes</b>                                                                                                                                                                                                      |                                                  |                                             |
| <b>Etc.</b>                                                                                                                                                                                                                   |                                                  |                                             |
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- c. My infant's/infants' health information may be exchanged with his/her health care provider:  
 Yes    No      Provider Name

**Check the appropriate box and write the name of the infant's medical provider. If you are securing this when mom is pregnant and you don't yet have the name of infant(s) medical provider, you may check yes and write TBD. When the clinic is chosen, the name of the provider may be written in and initialed and dated.**

**When securing 2 separate releases—as noted in item 2 at the top of page one—it is recommended that you draw a line through this section when the consent to release is for pregnant woman's PHI.**

- d. My infant's/infants' health information may be exchanged with the following parties:

| Name of provider or facility                                                                                                                                                                                                  | Date                                             | Initialed by Beneficiary                    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------|
| <i>Write the name of the provider or facility for exchange of PHI here. Typical contacts (i.e. DHS, WIC, Food banks, etc.) may be pretyped since the client's initials and date signifies that release of PHI is approved</i> | <i>The date of the initials is required here</i> | <i>Initials are required in this column</i> |
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| <b>WIC</b>                                                                                                                                                                                                                    |                                                  |                                             |
| <b>Early On</b>                                                                                                                                                                                                               |                                                  |                                             |
| <b>DHS</b>                                                                                                                                                                                                                    |                                                  |                                             |
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NOTE: If there are multiple infants in the family who are being seen by different health care providers or service providers, you may designate which infant's information may be exchanged with each provider.

2. I understand that this may 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).
3. I understand that:
  - a. Consenting to the exchange of this health information is voluntary.
  - b. I may refuse to sign this consent.
  - c. My refusal to sign will not affect my Medicaid eligibility or benefits.
4. I understand that if I give consent:
  - a. I have the right to change my mind and cancel it at any time.
  - b. I will give written notice to the *Your agency names goes here* (MIHP agency) that maintains my record if I decide to cancel it.
5. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules.
6. I understand that any uses or releases already made with my consent cannot be taken back.
7. I understand that I may request a copy of this signed consent.
8. I understand that this consent will expire at the end of MIHP services unless I cancel it before then.

I have read the above or it has been read and explained to me.  
 I understand that I may receive MIHP services without consenting to release my protected health information.

*Please check the appropriate box*

I DO consent to the release of protected health information as specified in this form.

I DO NOT consent to the release of protected health information as specified in this form.

*Beneficiary name here*  
 Beneficiary Name (Print)

*If infant, write legal rep name here / If infant, write legal rep relationship here. You do not need to complete this line is pregnant woman is the beneficiary*  
 Legal Representative/Relationship to Beneficiary

*Beneficiary (pregnant age 12 or older) or legal rep (if infant or pregnant & under age 12) signs here*  
 Signature of Beneficiary or Legal Representative

*Write date signed here*  
 Date

*MIHP professional (RN or SW only) signs here*

*Write date signed here*

Signature of MIHP Interviewer

Date