Permission to Share Behavioral Health Information

Use this form to give or take away your permission to share information about your:

- Mental and behavioral health services. This will be referred to as “behavioral health” throughout this form.
- Referrals and treatment for an alcohol or substance use disorder.

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 permission 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 permission to share your behavioral health or substance use records. Learn more at michigan.gov/bhconsent.

Instructions

- To **give** permission, fill out Sections 1, 2, 3, and 4.
- To **take** away permission, fill out Sections 5 and 6.
- Sign the completed form, then give it to your health care provider. They can make a copy for you.

Give Your Permission

Section 1: About you

First name	Middle initial	Last name	Date of birth	ZIP code	Gender

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 information. You may list health care providers, health plans, family members, or others. They can only share your records with people or organizations listed below.

1.	5.
2.	6.
3.	7.
4.	8.

Section 2b: Sharing information electronically

Health information exchanges or networks share health 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 one option:

☐ Share my information through the organizations listed below.

☐ 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. To see who has viewed your records, you can request a list in writing.

For health care provider or health plan use only. List all health information exchanges or networks:

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

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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 notes taken during counseling sessions. These are often called “psychotherapy notes”.

☐ Share **only** the types of behavioral health and substance use disorder records listed below. For example, what I’m being treated for, my medications, lab results, etc.

1.	3.
2.	4.

Section 4: Your permission and signature

Read the statements below, then sign and date the form.

By signing this form below, I understand:

- I am giving permission 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 don’t fill it out, I can still get treatment, health insurance or benefits. But, without this form, providers 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 does not need my permission 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 permission to share notes taken during counseling sessions (these are often called “psychotherapy notes”).
- I can remove my permission 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 permission.
- I have read this form. Or it’s 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 one 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.)

  End date, event, or condition: ______________________________

State your relationship to the person giving permission and then sign and date below:

☐ Self

☐ Parent (print name) ______________________________

☐ Guardian (print name) ______________________________

☐ Authorized representative (print name) ______________________________

Signature	Date

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Take away your permission

Complete this section if you no longer want to share your records listed above in Section 3.

Section 5: About you

First name	Middle initial	Last name	Date of birth	ZIP code	Gender

Section 6: 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 giving permission, then sign and date below.

☐ Self
☐ Parent (print name) ______________________
☐ Guardian (print name) ______________________
☐ Authorized representative (print name) ______________________

Signature	Date

For health care provider or health plan only

Verbal withdrawal of permission

☐ The individual listed above in Section 5 has taken away his/her permission. (Complete Section 5 if needed).

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

☐ Self
☐ 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/organizations at michigan.gov/bhconsent.

Additional identifiers (optional):

Medicaid ID:

Last 4 of Social Security Number:

Form copy (choose one):

☐ The individual above **received** a copy of this form.
☐ The individual above **declined** a copy of this form.

Authority:	This form is acceptable to the Michigan Department of Health and Human Services as compliant with 45 CFR Parts 160 and 164 as modified August 14, 2002, 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.

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