

Michigan WIC Client Signature Process

Please follow the steps below to help you sign certain documents while participating with the WIC Program. The WIC Client Agreement is required to be signed and the Physician Authorization can be signed if you wish to allow WIC to share your information with your health care provider. You can complete and sign both forms using:

1. WIC Connect Mobile App
2. WIC Connect Online Portal
3. Adobe Acrobat Reader App on a Smart Phone

Please use the table of contents to go directly to the set of instructions you are interested in.

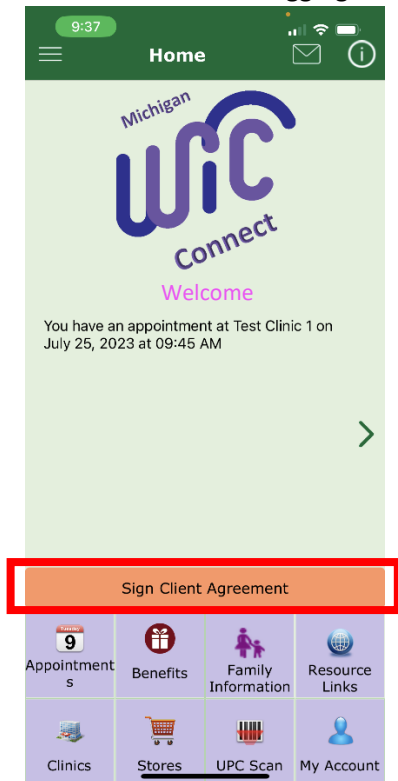
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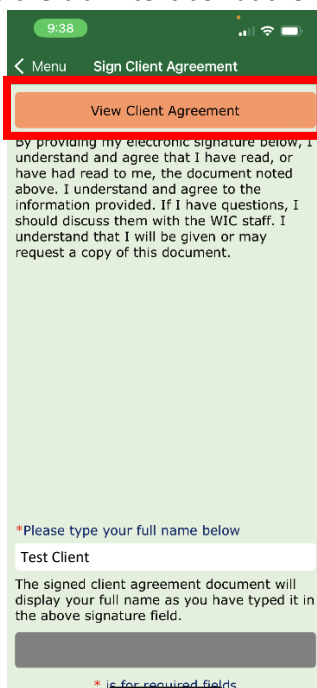
Sign the Client Agreement

1. WIC Connect Mobile App

1. Before your certification or recertification appointment, click the orange 'Sign Client Agreement' button on your home screen after logging in to the WIC Connect Mobile App.



2. You will be taken to the 'Sign Client Agreement' screen where you can click 'View Client Agreement' to view a PDF version of the Client Agreement. After reviewing the Client Agreement, please type your full name into the blank text box at the bottom of the screen to sign the agreement.



- Once you have typed your name in the box, the 'Agree' button will display as orange. Click 'Agree,' and a confirmation message will appear.

9:38

< Menu Sign Client Agreement

View Client Agreement

By providing my electronic signature below, I understand and agree that I have read, or have had read to me, the document noted above. I understand and agree to the information provided. If I have questions, I should discuss them with the WIC staff. I understand that I will be given or may request a copy of this document.

*Please type your full name below

Test Client

The signed client agreement document will display your full name as you have typed it in the above signature field.

Agree

* is for required fields

- Click 'OK' to be redirected to the homepage.

9:38

< Menu Sign Client Agreement

The client agreement has been signed.

Ok

Sign the Client Agreement

2. WIC Client Connect Online Portal

1. Before your certification or recertification appointment, click the link at the top of your home page after logging in to the WIC Client Connect Online Portal that says, 'Action Item: You have documents to sign! Click here to review.'

WIC Family Home Page

Action Item: You have documents to sign! Click here to review.

Certifications

Client Name	Birth Date	Category	Certification ...	Certification ...
Infant Client	9/30/2014	C1	4/21/2015	4/26/2016
Child Client	4/1/2011	C4	10/30/2014	10/29/2015
Test Client	3/30/1980	PG	10/30/2014	8/18/2015

Previous Appointments

Client Name	Categ...	Appointmen...	Date & Time of Ap...	Clinic	Attendance
Test Client	PG	CERT	7/25/2023 9:00:00 AM	Test Clinic 1	<input type="checkbox"/>
Test Client	PG	CERT	7/25/2023 9:00:00 AM	Test Clinic 1	<input type="checkbox"/>

Future Appointments

Client Name	Category	Appointment ...	Date & Time of Ap...	Clinic	Please Rem...
Test Client	PG	CERT	07/25/2023 09:45:00	Test Clinic 1	Please bring ID ...

Requested Appointments

Client Name	Category	Start Date	End Date	Preferred Time	Clinic
No Records Exist in Data Source					

[Check in](#) [Request an appointment](#)

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Database: miwicp

[Michigan.gov Home](#) [State Web Sites](#) [Contact WIC](#) [MDHHS Home](#) [Michigan Policies](#)

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2. You will be taken to the 'Client Agreement' screen where you can click a link to review a PDF version of the Client Agreement. After reviewing the Client Agreement, please type your full name into the blank text box at the bottom of the screen to sign the agreement.

MDHHS Healthcare 4 Michigan Department of Health and Human Services Michigan WIC Client Connect

Michigan.gov Home Application Home Contact WIC MDHHS Home

English Español

Active Record

Test, Client
Family ID: 1234567

My WIC Account

Update Family Info

My Benefits Balance

PDF Forms

WIC Clinics

WIC Grocery Stores

WIC Resources Links

Mylogin Profile

Logout

Client Agreement

[Download the Client Agreement document](#)

By providing my electronic signature below, I understand and agree that I have read, or have had read to me, the document noted above. I understand and agree to the information provided. If I have questions, I should discuss them with the WIC staff. I understand that I will be given or may request a copy of this document.

Please type your full name below*:

The signed client agreement document will display your full name as you have typed it in the above signature field.

* Indicates a required field

Accept Close

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3. Once you have typed your name in the box, click 'Accept' to be taken to the 'PDF Forms' grid where you can view your signed agreement.

MDHHS Healthcare 4 Michigan Department of Health and Human Services Michigan WIC Client Connect

Michigan.gov Home Application Home Contact WIC MDHHS Home

English Español

Active Record

Test, Client
Family ID: 1234567

My WIC Account

Update Family Info

My Benefits Balance

PDF Forms

WIC Clinics

WIC Grocery Stores

WIC Resources Links

Mylogin Profile

Logout

Client Agreement

[Download the Client Agreement document](#)

By providing my electronic signature below, I understand and agree that I have read, or have had read to me, the document noted above. I understand and agree to the information provided. If I have questions, I should discuss them with the WIC staff. I understand that I will be given or may request a copy of this document.

Please type your full name below*:

Connie Test

The signed client agreement document will display your full name as you have typed it in the above signature field.

* Indicates a required field

Accept Close

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English Español

Active Record

Test, Client
Family ID: 1234567

My WIC Account

Update Family Info

My Benefits Balance

PDF Forms

WIC Clinics

WIC Grocery Stores

WIC Resources Links

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Logout

PDF Forms

Select Documents To Be Printed

Document
Shopping List
NE Plan
Verification of Certification
Referral Notification
Client Agreement
Client Vendor Listing
Client Growth Chart

Preview

Close

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Database: miwcp

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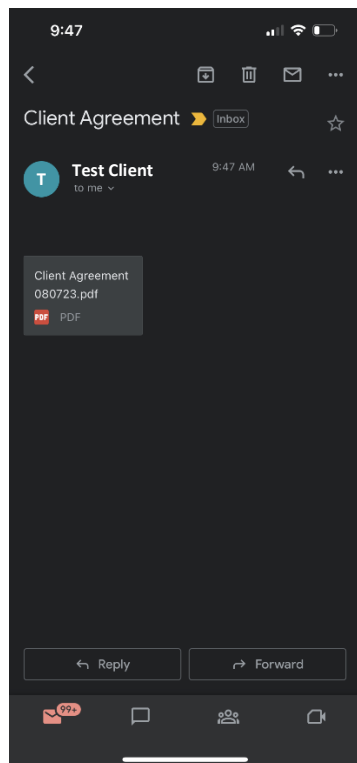
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Sign the Client Agreement

3. Adobe Acrobat Reader App on a Smart Phone

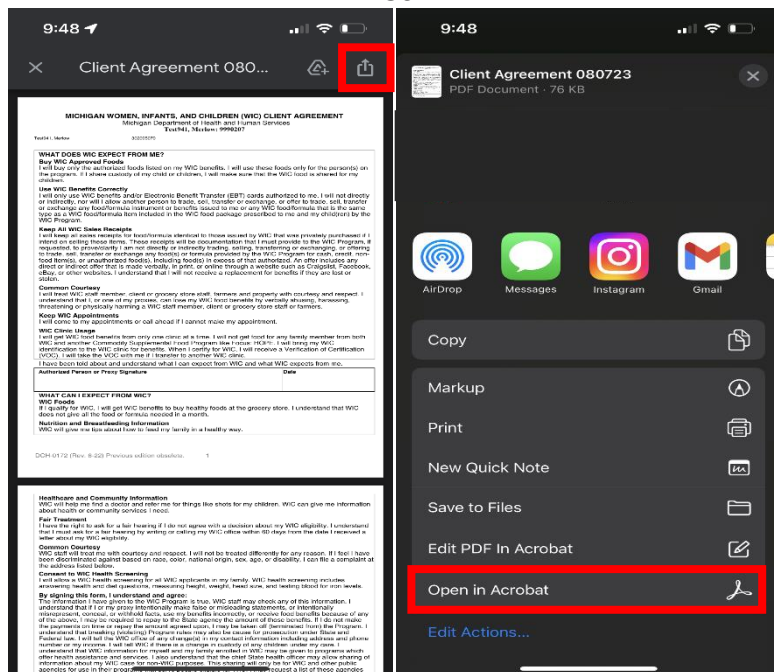
If you have another PDF reader on your smart phone that allows you to sign documents, you do not need to download Adobe Acrobat Reader.

1. Download Adobe Acrobat Reader from the Apple App Store or Google Play.
2. If you received your WIC Client Agreement via email, click on the PDF in the email.

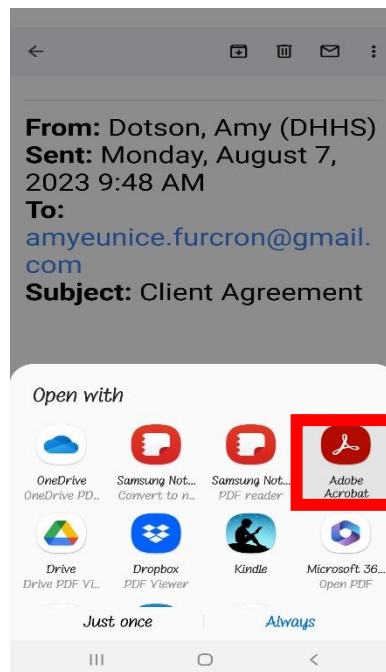


3. Once the PDF is open, choose application you will use to edit the PDF.

iOS



Android



4. Once the agreement is open, select 'Fill & Sign' to complete.

iOS

Android

5. Select the pen icon, add signature, and then to draw your signature in the box, and select 'Done'.

iOS

Android

iOS

9:49

Done

MICHIGAN WOMEN, INFANTS, AND CHILDREN (WIC) CLIENT AGREEMENT
Michigan Department of Health and Human Services
Test#41, Merlow: 89962027

Test#41, Merlow: 89962027

WHAT DOES WIC EXPECT FROM ME?
Buy WIC Approved Foods
I will buy only the authorized foods listed on my WIC benefits. I will use these foods only for the person(s) on the program. If I share custody of my child or children, I will make sure that the WIC food is shared for my children.
Use WIC Benefits Correctly
I will only use WIC benefits and/or Electronic Benefit Transfer (EBT) cards authorized to me. I will not directly or indirectly, nor will I allow another person to trade, sell, transfer or exchange, or offer to trade, sell, transfer or exchange any foodformula instrument or benefits issued to me or any WIC foodformula that is the same type as a WIC foodformula item included in the WIC food package prescribed to me and my child(ren) by the WIC Program.
Keep All WIC Sales Receipts
I will keep all sales receipts for foodformula identical to those issued by WIC that was privately purchased if I intend on selling these items. These receipts will be documentation that I must provide to the WIC Program, if requested, to prove that I am not directly or indirectly trading, selling, transferring or exchanging, or offering to trade, sell, transfer or exchange any food(s) or formula provided by the WIC Program for cash, credit, non-food item(s), or unauthorized food(s), including food(s) in excess of that authorized. An offer includes any direct or indirect offer that is made verbally, in print, or online through a website such as Craigslist, Facebook, eBay, or other websites. I understand that I will not receive a replacement for benefits if they are lost or stolen.
Common Courtesy
I will treat WIC staff member, client or grocery store staff, farmers and property with courtesy and respect. I understand that I, or one of my guests, can lose my WIC food benefits by verbally abusing, harassing, threatening or physically harming a WIC staff member, client or grocery store staff or farmers.
Keep WIC Appointments
I will come to my appointments or call ahead if I cannot make my appointment.
WIC Clinic Usage
I will get WIC food benefits from only one clinic at a time. I will not get food for any family member from both WIC and another Commodity Supplemental Food Program like Focus: HOPE. I will bring my WIC identification to the WIC clinic for benefits. When I certify for WIC, I will receive a Verification of Certification (VOC). I will take the VOC with me if I transfer to another WIC clinic.
I have been told about and understand what I can expect from WIC and what WIC expects from me.

Authorized Person or Proxy Signature _____ Date _____

WHAT CAN I EXPECT FROM WIC?
WIC Foods
If I qualify for WIC, I will get WIC benefits to buy healthy foods at the grocery store. I understand that WIC does not give all the food or formula needed in a month.
Nutrition and Breastfeeding Information
WIC will give me tips about how to feed my family in a healthy way.

DCH-0172 (Rev. 6-22) Previous edition obsolete. 1

Healthcare and Community Information
WIC will provide food a shop and information for things like shops for my children. WIC can give me information.

Add signature +

Add initials +

Android

✓

MICHIGAN WOMEN, INFANTS, AND CHILDREN (WIC) CLIENT AGREEMENT
Michigan Department of Health and Human Services
Test#41, Merlow: 89962027

Test#41, Merlow: 89962027

WHAT DOES WIC EXPECT FROM ME?
Buy WIC Approved Foods
I will buy only the authorized foods listed on my WIC benefits. I will use these foods only for the person(s) on the program. If I share custody of my child or children, I will make sure that the WIC food is shared for my children.
Use WIC Benefits Correctly
I will only use WIC benefits and/or Electronic Benefit Transfer (EBT) cards authorized to me. I will not directly or indirectly, nor will I allow another person to trade, sell, transfer or exchange, or offer to trade, sell, transfer or exchange any foodformula instrument or benefits issued to me or any WIC foodformula that is the same type as a WIC foodformula item included in the WIC food package prescribed to me and my child(ren) by the WIC Program.
Keep All WIC Sales Receipts
I will keep all sales receipts for foodformula identical to those issued by WIC that was privately purchased if I intend on selling these items. These receipts will be documentation that I must provide to the WIC Program, if requested, to prove that I am not directly or indirectly trading, selling, transferring or exchanging, or offering to trade, sell, transfer or exchange any food(s) or formula provided by the WIC Program for cash, credit, non-food item(s), or unauthorized food(s), including food(s) in excess of that authorized. An offer includes any direct or indirect offer that is made verbally, in print, or online through a website such as Craigslist, Facebook, eBay, or other websites. I understand that I will not receive a replacement for benefits if they are lost or stolen.
Common Courtesy
I will treat WIC staff member, client or grocery store staff, farmers and property with courtesy and respect. I understand that I, or one of my guests, can lose my WIC food benefits by verbally abusing, harassing, threatening or physically harming a WIC staff member, client or grocery store staff or farmers.
Keep WIC Appointments
I will come to my appointments or call ahead if I cannot make my appointment.
WIC Clinic Usage
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I have been told about and understand what I can expect from WIC and what WIC expects from me.

Authorized Person or Proxy Signature _____ Date _____

WHAT CAN I EXPECT FROM WIC?
WIC Foods
If I qualify for WIC, I will get WIC benefits to buy healthy foods at the grocery store. I understand that WIC does not give all the food or formula needed in a month.
Nutrition and Breastfeeding Information
WIC will give me tips about how to feed my family in a healthy way.

Add signature +

Add initials +

|||

iOS

Cancel

Draw Image Camera

Done

Sign

Clear

Save to Online Profile

Android

Cancel

Draw Image Camera

Done

Sign

Clear

Save online

6. Next, tap the signature box, enter the date, and hit the share button in the top right corner of the screen.

iOS

iOS

August 10, 2023

Android

Android

staff, farmers and property with courtesy and respect. I
WIC food benefits by verbally abusing, harassing,
ar, client or grocery store staff or farmers.

not make my appointment.

ime. I will not get food for any family member from both
ogram like Focus: HOPE. I will bring my WIC
rtify for WIC, I will receive a Verification of Certification
ther WIC clinic.

pect from WIC and what WIC expects from me.

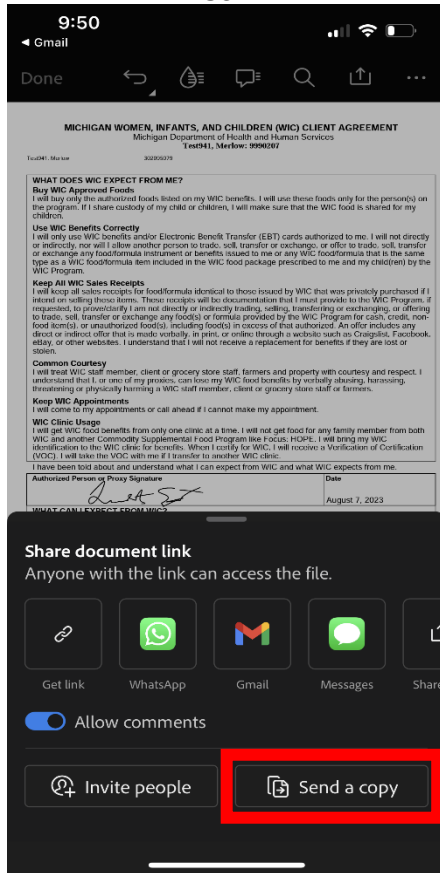
Date
08/07/2023

thy foods at the grocery store. I understand that WIC

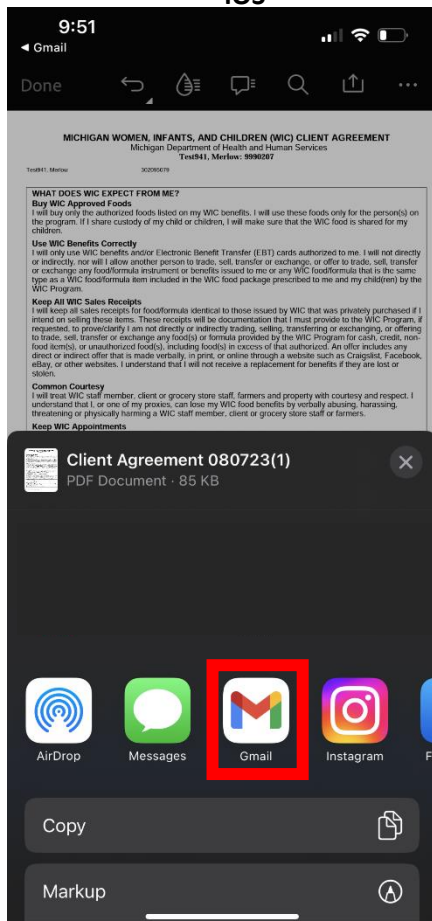
[Back to Table of Contents](#)

7. Select 'Send a copy' and the application you would like to send an email.

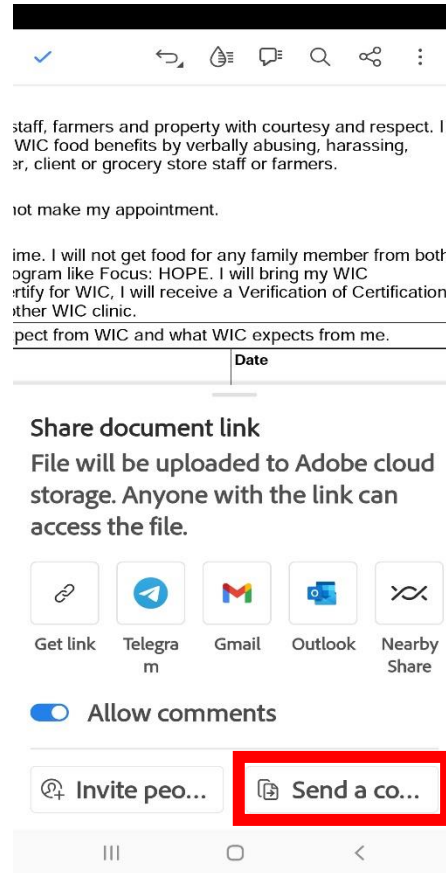
iOS



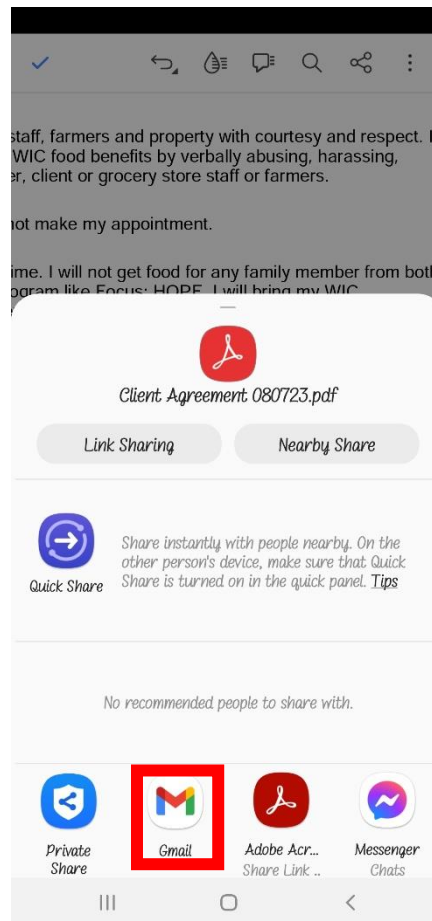
iOS



Android

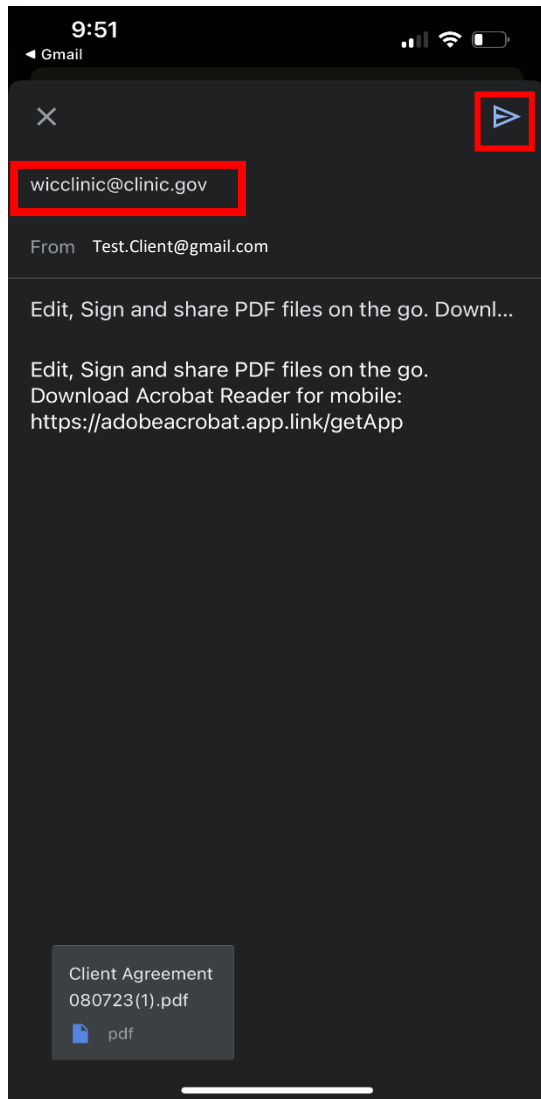


Android

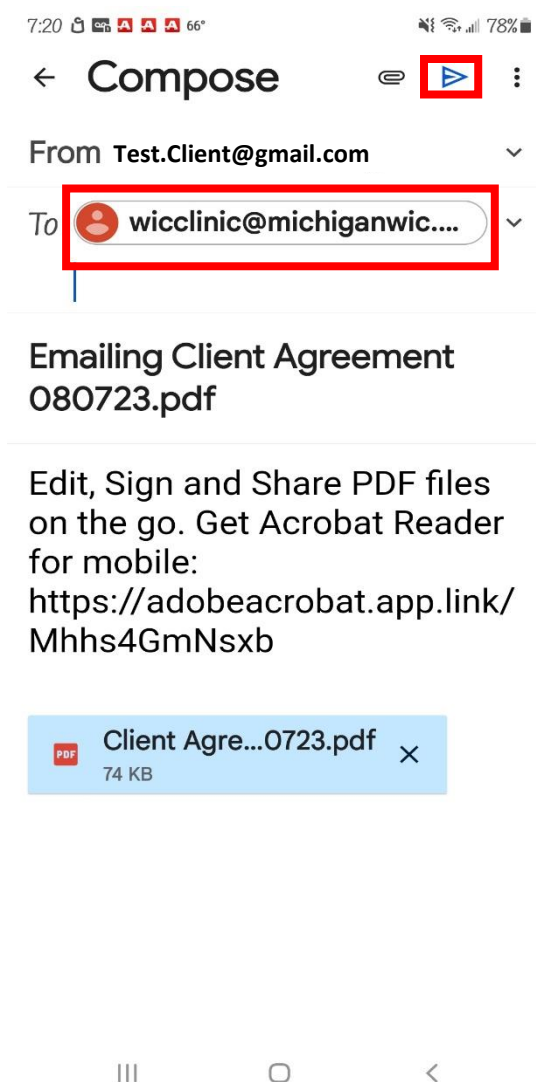


8. Type your WIC Clinic's email address in the email address bar and hit send.

iOS



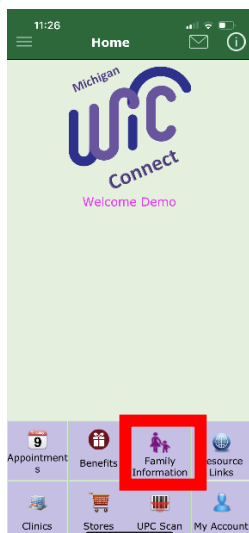
Android



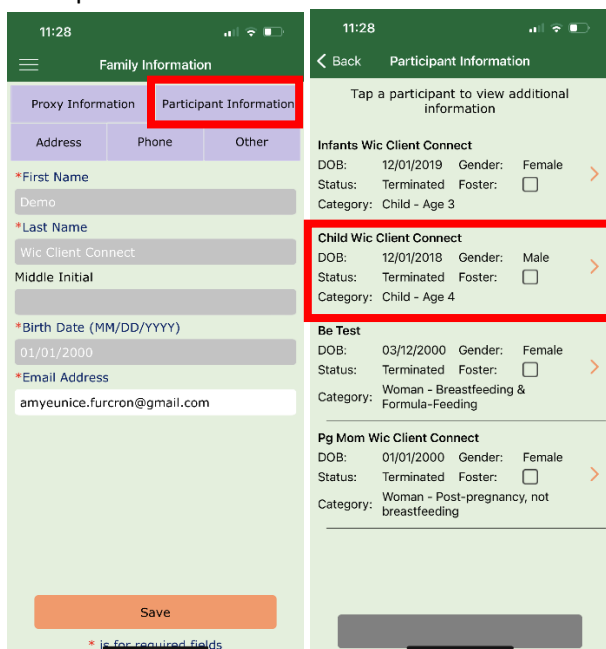
Sign the Physician Authorization Form

1. WIC Connect Mobile App

1. Log in to the WIC Connect Mobile App and click the 'Family Information' icon.



2. Next, click the 'Participant Information' button and select the family member that needs the authorization form completed.



- For the selected family member, type in their physician's name. The 'Sign Physician Authorization' button will turn orange. Click this to sign the form.

3:04 View Participant

*First Name Maria

*Last Name Test92

Middle Initial

*Birth Date (MM/DD/YYYY) 06/07/1994

*Gender Female

*Client Category Woman - Breastfeeding Only

Foster Status ☐

Marital Status Married

Education Level 5th grade

Medicaid Card ID

Physician Name

Physician Phone

Sign Physician Authorization

Hispanic or Latino? ☒ Yes ☐ No

Race If multiracial, please select all that apply from the list

☐ American Indian or Alaskan Native

Ok

* is for required fields

- You will need to complete each portion of the form:

3:05 Physician Authorization

Please fill out the following fields to provide Authorization to release WIC Information:

I, Authorized Person/Participant, authorize Michigan WIC to release information contained in WIC Client Record (anthropometric data, diet recommendations, breastfeeding information, etc.) for:

- Maria Test92

to the following physician(s):

☒ Dr. Love

Please list additional Physicians, if any:

Add Additional Physician

*I, Authorized Person/Participant, give Michigan WIC permission to share my communicable disease status (including HIV), information about my alcohol or drug abuse treatment history, and/or my mental health treatment history.

☒ Yes ☐ No

*Initial Here (Authorized Person/Participant): MT

Please specify information that should NOT be disclosed, if any:

I understand that I have the right to refuse

- Check the box next to the Physician's name.
- Add additional physician(s) as needed.
- Check the box to give their authorization.
- Enter your initials.
- List any information that should not be disclosed.
- Type your full name in the text box to sign the form.

5. Once the form is completed, you will click the 'Accept' button, and the below message will be displayed.

The left screenshot shows the 'Physician Authorization' form. It includes a consent statement, a checkbox for 'Yes' (checked) and 'No', a field for 'Initial Here (Authorized Person/Participant):' with the value 'MT', and a text area for 'Please specify information that should NOT be disclosed, if any:'. Below this is a statement of understanding and a field for 'Please type your full name below:' with the value 'Maria Test'. The 'Accept' button is highlighted with a red border.

The right screenshot shows the 'View Participant' screen. A 'Success' dialog box is displayed over the form, stating 'Physician authorization was saved successfully.' with an 'Ok' button. The background form shows fields for 'Last Name' (Test92), 'Birth Date' (06/07/1994), 'Gender' (Female), 'Client Category' (Woman - Breastfeeding Only), 'Foster Status' (unchecked), 'Marital Status' (Married), 'Education' (Married), 'Medical Card ID', 'Physician Name' (Dr. Love), 'Physician Phone', 'Update Physician Authorization' button, 'Hispanic or Latino?' (checked Yes), 'Race' (American Indian or Alaskan Native), and an 'Ok' button.

6. You can view or make changes to the form by clicking the 'Save' icon next to the 'Update Physician Authorization' button.

The screenshot shows the 'View Participant' screen. It includes fields for 'First Name' (Child), 'Last Name' (Wic Client Connect), 'Middle Initial', 'Birth Date' (12/01/2018), 'Gender' (Male), 'Client Category' (Child - Age 4), 'Foster Status' (unchecked), 'Medicaid Card ID', 'Physician Name', 'Physician Phone', 'Hispanic or Latino?' (checked Yes), 'Race' (American Indian or Alaskan Native), and an 'Ok' button. The 'Update Physician Authorization' button is highlighted with a red border, and a 'Save' icon is visible next to it.

Sign the Physician Authorization Form

2. WIC Client Connect Online Portal

1. Log into the WIC Client Connect online portal and click 'Schedule an appointment'.



Michigan.gov Home Application Home Contact WIC MDHHS Home Help English Español عربي

WIC Family Home Page

Active Record
Test, Client

My Account
WIC Clinics
WIC Grocery Stores
WIC Resources Links
Link to my WIC Information
Mlogin Profile
Logout

Future Appointments

Client Name	Category	Appointment ...	Date & Time of Ap...	Clinic	Please Rem...
No Records Exist in Data Source					

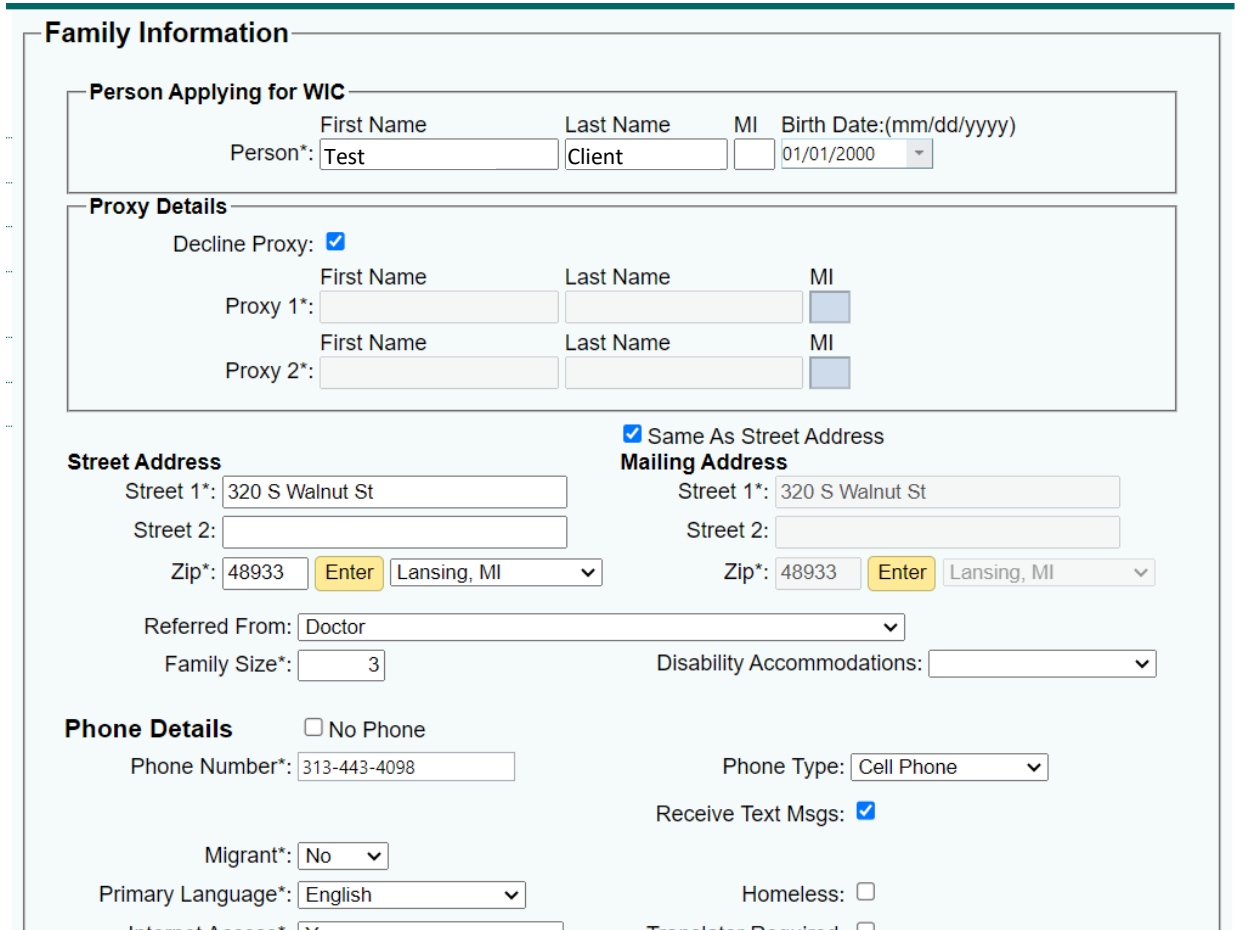
[Cancel Appointment](#) [Reschedule Appointment](#) [Schedule an appointment](#)

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2. You will be taken to the 'Family Information' screen. Scroll down to the 'Participant Information' section.



Family Information

Person Applying for WIC

Person*: First Name: Test Last Name: Client MI: Birth Date:(mm/dd/yyyy): 01/01/2000

Proxy Details

Decline Proxy: ☒

Proxy 1*: First Name: Last Name: MI:

Proxy 2*: First Name: Last Name: MI:

☒ Same As Street Address

Street Address

Street 1*: 320 S Walnut St

Street 2:

Zip*: 48933 Enter Lansing, MI

Mailing Address

Street 1*: 320 S Walnut St

Street 2:

Zip*: 48933 Enter Lansing, MI

Referred From: Doctor

Family Size*: 3

Disability Accommodations:

Phone Details

☐ No Phone

Phone Number*: 313-443-4098

Phone Type: Cell Phone

Receive Text Msgs: ☒

Migrant*: No

Primary Language*: English

Homeless: ☐

Internet Access*: Yes

Translator Required: ☐

- Click the row of the family member that needs the authorization form completed and select 'View Participant'.

Participant Information

	First Name	Last Name	MI	Birth Date	Gender	Fo...	Category	Status
	Infant	Test		09/24/2022	Female	No	Infant - Breastfeeding Only	
▶	Client	Test		01/01/2000	Female	No	Woman - Pregnant	

[View Participant](#)
[Edit Participant](#)
[Add Participant](#)
[Remove Participant](#)

* Indicates a required field

[Continue](#)
[Close](#)

- Enter the selected family member's Physician Name to click on the 'Sign or Update Physician Authorization' button.

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Department of Health and Human Services
Michigan WIC Client Connect

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English Español

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My Login Profile
Logout

Add Participant

First Name*: Client Middle Initial: Last Name*: Test

Birth Date (MM/DD/YYYY): 1/1/2000 Gender*: Female

Client Category*: Woman - Pregnant Foster: ☐

Marital Status: Married Education Level: 4 or 5 years of college

Medicaid Card ID Number:

Physician Name*: Physician Phone Number:

[Sign or Update Physician Authorization](#)

Hispanic Or Latino?: ☐ Yes ☐ No

Race: If multiracial, please select all that apply from the list:

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ European
☐ North African
☐ Middle Eastern

As per Civil Rights regulation, this is optional. Be advised, however, if you do not self-identify an agency employee will assign a category for you.

* Indicates a required field

Save Close

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Version: 3.5.0.0 Database: miwicp

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MDHHS Healthcare4Michigan
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Michigan WIC Client Connect

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English Español

Active Record
Test, Client
My Account
WIC Clinics
WIC Grocery Stores
WIC Resources Links
Link to my WIC Information
My Login Profile
Logout

Add Participant

First Name*: Client Middle Initial: Last Name*: Test

Birth Date (MM/DD/YYYY): 1/1/2000 Gender*: Female

Client Category*: Woman - Pregnant Foster: ☐

Marital Status: Married Education Level: 4 or 5 years of college

Medicaid Card ID Number:

Physician Name*: Dr. Love Physician Phone Number: 555-555-1234

[Sign or Update Physician Authorization](#)

Hispanic Or Latino?: ☒ Yes ☐ No

Race: If multiracial, please select all that apply from the list:

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ European
☐ North African
☐ Middle Eastern

As per Civil Rights regulation, this is optional. Be advised, however, if you do not self-identify an agency employee will assign a category for you.

* Indicates a required field

Save Close

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Version: 3.5.0.0 Database: miwicp

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5. Once there, complete the required sections, and click the 'Accept' button at the bottom of the screen.

The screenshot shows the 'Michigan WIC Client Connect' web application. The header includes the MDHHS logo and navigation links. The left sidebar contains links like 'Active Record', 'Test, Client', and 'My Account'. The main content area is titled 'Physician Authorization' and contains the following sections:

- Physician Authorization:** A heading followed by instructions to fill out fields for authorization.
- I, Authorized Person/Participant, authorize Michigan WIC to release information contained in WIC Client Record (anthropometric data, diet recommendations, breastfeeding information, etc.) for:** A statement with a radio button selected for 'Test Client'.
- to the following physician(s):** A section with a checkbox for 'Dr. Love' and a text box for additional physicians.
- Physician Name:** A table with one row containing 'No Records Exist in Data Source'.
- Add Remove:** Two buttons for managing the list of physicians.
- * I (Authorized Person/Participant) give Michigan WIC permission to share my communicable disease status (including HIV), information about my alcohol or drug abuse treatment history, and/or my mental health treatment history:** A section with radio buttons for 'Yes' (selected) and 'No'.
- * Initial Here (Authorized Person/Participant):** A text box containing 'AD'.
- Please specify information that should NOT be disclosed, if any:** A text box.
- I understand that I have the right to refuse releasing said information without consequences to my WIC benefits. I understand that once my health information is released under this authorization, the potential exists for that information to be re-disclosed by the person receiving my information.** A statement.
- * Please type your full name below:** A text box containing 'Test Client'.
- The signed physician's authorization will display your full name as you have typed it in the above signature field.** A statement.
- Accept Cancel:** Two buttons at the bottom right, with 'Accept' highlighted in red.

At the bottom of the page, there is a footer with the text 'This institution is an equal opportunity provider.' and a version number 'Version: 3.5.0.0'.

- Check the box next to the Physician's name.
- Add additional physician(s) as needed.
- Check the box to give their authorization.
- Enter your initials.
- List any information that should not be disclosed.
- Type your full name in the text box to sign the form.

6. After completing the form, you will be taken back to 'Participant' screen where you will have the option to 'Sign or Update Physician Authorization' or 'View Signed Physician Authorization'.

First Name*:

Middle Initial:

Last Name*:

Birth Date (MM/DD/YYYY)*:

Gender*:

Client Category*:

Foster: ☐

Medicaid Card ID Number:

Physician Name*:

Physician Phone Number:

Sign or Update Physician Authorization

View Signed Physician Authorization

Hispanic Or Latino?: ☐ Yes ☒ No

Race: If multiracial, please select all that apply from the list:

☐ American Indian or Alaska Native

☐ Asian

☒ Black or African American

☐ Native Hawaiian or Other Pacific Islander

☒ White

☒ European

☐ North African

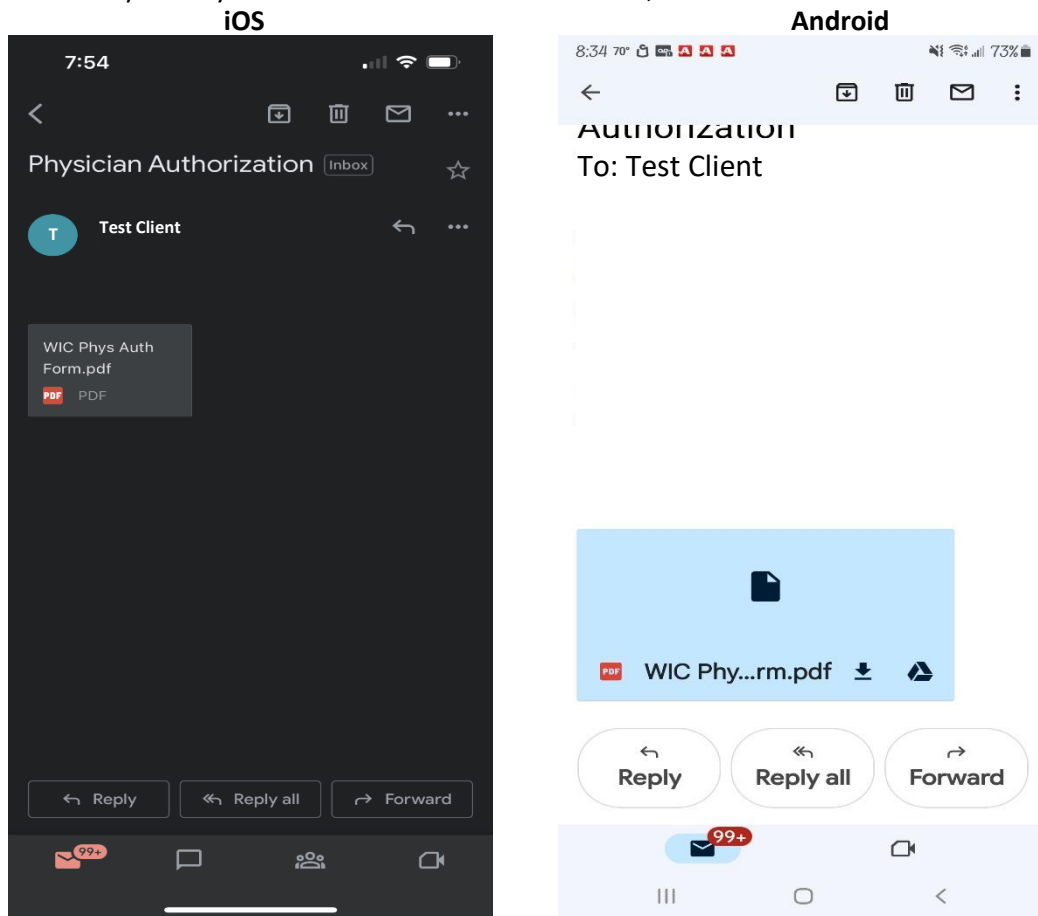
☐ Middle Eastern

Sign the Physician Authorization Form

3. Adobe Acrobat Reader App on a Smart Phone

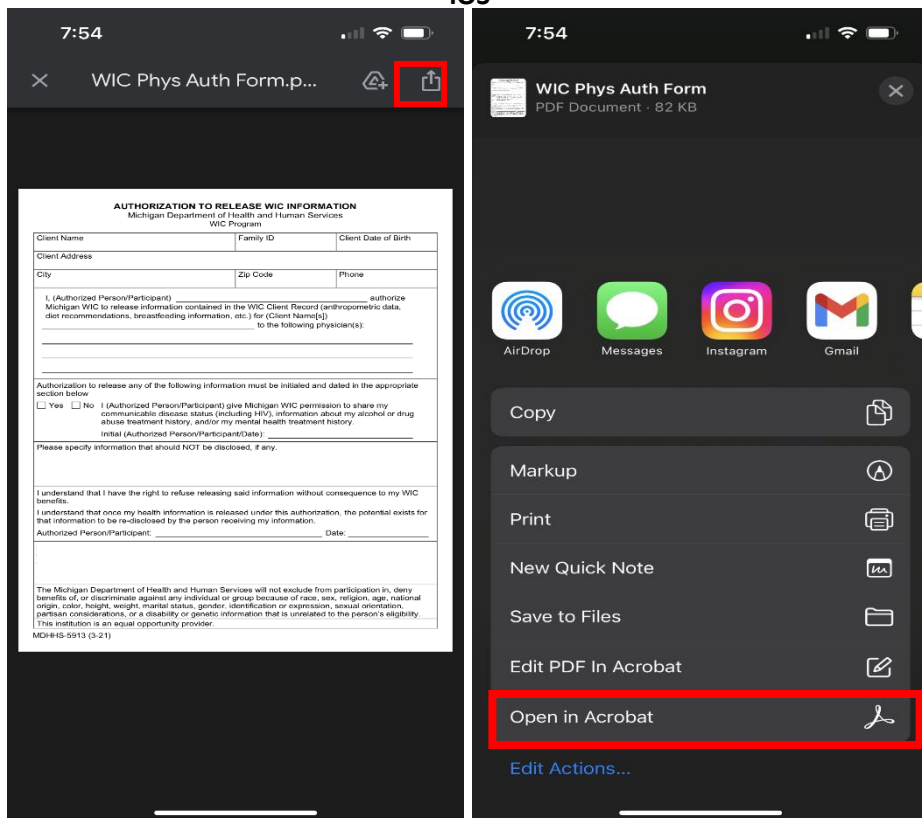
If you have another PDF reader on your smart phone that allows you to sign documents, you do not need to download Adobe Acrobat.

1. Download Adobe Acrobat Reader from the Apple App Store or Google Play.
2. If you received your Physician Authorization Form via email, click on the PDF in the email.

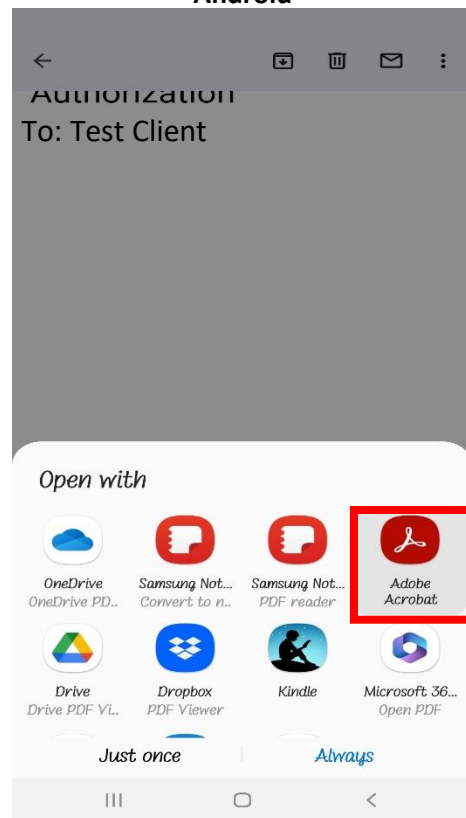


3. Once the PDF is open, you will select which application you will use to edit the PDF.

iOS

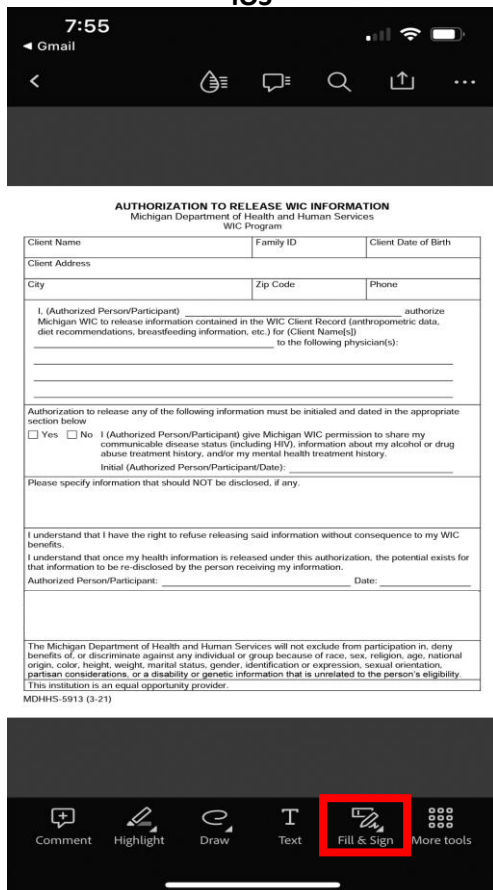


Android

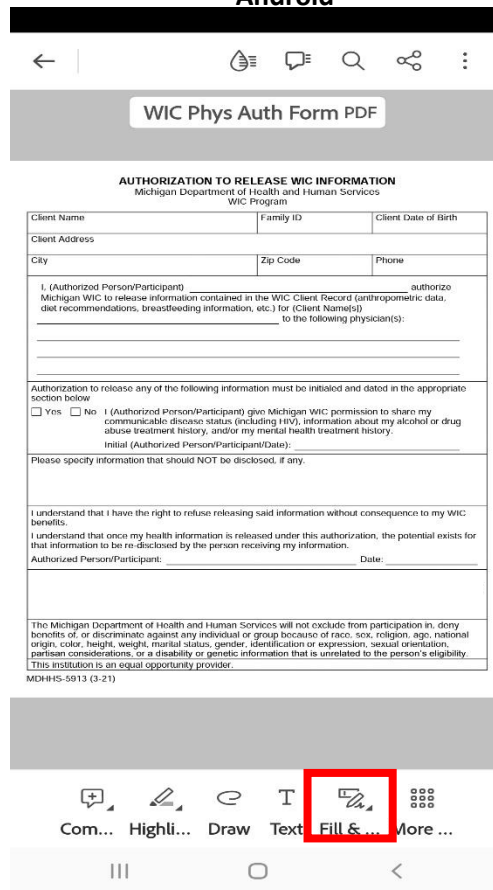


4. Select 'Fill & Sign' to complete the form and add your signature and the date.

iOS

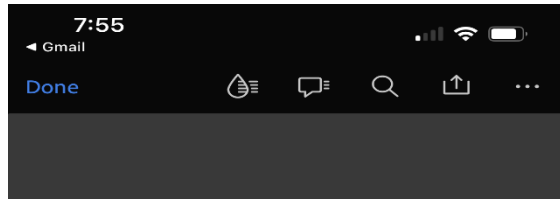


Android



- Select the text option, and then click in each box to complete the form.

iOS



AUTHORIZATION TO RELEASE WIC INFORMATION
Michigan Department of Health and Human Services
WIC Program

Client Name	Family ID	Client Date of Birth
Client Address		
City	Zip Code	Phone

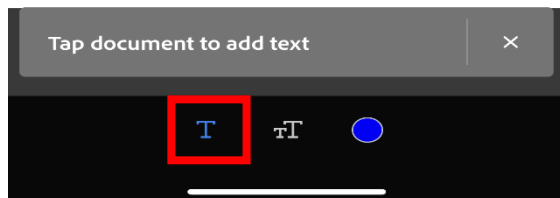
I, (Authorized Person/Participant) _____ authorize Michigan WIC to release information contained in the WIC Client Record (anthropometric data, diet recommendations, breastfeeding information, etc.) for (Client Name(s)) _____ to the following physician(s): _____

Authorization to release any of the following information must be initiated and dated in the appropriate section below
☐ Yes ☐ No I (Authorized Person/Participant) give Michigan WIC permission to share my communicable disease status (including HIV), information about my alcohol or drug abuse treatment history, and/or my mental health treatment history.
 Initial (Authorized Person/Participant/Date): _____

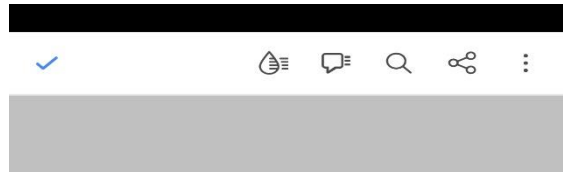
Please specify information that should NOT be disclosed, if any: _____

I understand that I have the right to refuse releasing said information without consequence to my WIC benefits.
 I understand that once my health information is released under this authorization, the potential exists for that information to be re-disclosed by the person receiving my information.
 Authorized Person/Participant: _____ Date: _____

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, gender, identification or expression, sexual orientation, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility. This institution is an equal opportunity provider.
 MDHHS-5913 (3-21)



Android



AUTHORIZATION TO RELEASE WIC INFORMATION
Michigan Department of Health and Human Services
WIC Program

Client Name	Family ID	Client Date of Birth
Client Address		
City	Zip Code	Phone

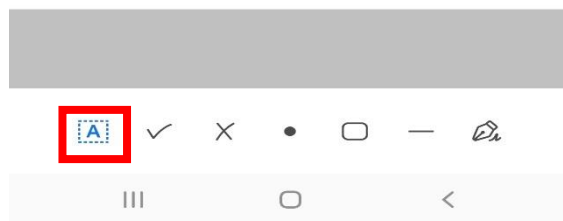
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 Initial (Authorized Person/Participant/Date): _____

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- Then select the pen icon, add your signature, select done, and tap to add your signature to the form.

iOS

AUTHORIZATION TO RELEASE WIC INFORMATION
Michigan Department of Health and Human Services
WIC Program

Client Name	Family ID	Client Date of Birth
Client Address		
City	Zip Code	Phone

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Android

AUTHORIZATION TO RELEASE WIC INFORMATION
Michigan Department of Health and Human Services
WIC Program

Client Name	Family ID	Client Date of Birth
Client Address		
City	Zip Code	Phone

I, (Authorized Person/Participant) _____ authorize Michigan WIC to release information contained in the WIC Client Record (anthropometric data, diet recommendations, breastfeeding information, etc.) for (Client Name(s)) _____ to the following physician(s): _____

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 Initial (Authorized Person/Participant/Date): _____

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 Authorized Person/Participant: _____ Date: _____

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 MDHHS-5913 (3-21)

iOS

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Gmail

Done

AUTHORIZATION TO RELEASE WIC INFORMATION
Michigan Department of Health and Human Services
WIC Program

Client Name	Family ID	Client Date of Birth
Client Address		
City	Zip Code	Phone

I, (Authorized Person/Participant) _____, authorize Michigan WIC to release information contained in the WIC Client Record (anthropometric data, diet recommendations, breastfeeding information, etc.) for (Client Name(s)) _____ to the following physician(s): _____

Authorization to release any of the following information must be initialed and dated in the appropriate section below:
☒ Yes ☐ No I (Authorized Person/Participant) give Michigan WIC permission to share my communicable disease status (including HIV), information about my alcohol or drug abuse treatment history, and/or my mental health treatment history.
 Initial (Authorized Person/Participant/Date): _____

Please specify information that should NOT be disclosed, if any: _____

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 Authorized Person/Participant: _____ Date: _____

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Android

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AUTHORIZATION TO RELEASE WIC INFORMATION
Michigan Department of Health and Human Services
WIC Program

Client Name	Family ID	Client Date of Birth
Client Address		
City	Zip Code	Phone

I, (Authorized Person/Participant) Test Family, authorize Michigan WIC to release information contained in the WIC Client Record (anthropometric data, diet recommendations, breastfeeding information, etc.) for (Client Name(s)) Test Family Children to the following physician(s): Dr. Love

Authorization to release any of the following information must be initialed and dated in the appropriate section below:
☒ Yes ☐ No I (Authorized Person/Participant) give Michigan WIC permission to share my communicable disease status (including HIV), information about my alcohol abuse treatment history, and/or my mental health treatment history.
 Initial (Authorized Person/Participant/Date): TF

Please specify information that should NOT be disclosed, if any: _____

I understand that I have the right to refuse releasing said information without consequence to my WIC benefits.
 I understand that once my health information is released under this authorization, the potential exists for that information to be re-disclosed by the person receiving my information.

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iOS

Cancel Draw Image Camera Done

uSis

Clear

Save to Online Profile

Android

Cancel Draw Image Camera Done

uSis

Clear

Save online

iOS

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Done

AUTHORIZATION TO RELEASE WIC INFORMATION
Michigan Department of Health and Human Services
WIC Program

Client Name _____ Family ID _____ Client Date of Birth _____

Client Address _____

City _____ Zip Code _____ Phone _____

I, (Authorized Person/Participant) _____ authorize Michigan WIC to release information contained in the WIC Client Record (anthropometric data, diet recommendations, breastfeeding information, etc.) for (Client Name(s)) _____ to the following physician(s): _____

Authorization to release any of the following information must be initiated and dated in the appropriate section below

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Initial (Authorized Person/Participant/Date): _____

Please specify information that should NOT be disclosed, if any.

I understand that I have the right to refuse releasing said information without consequence to my WIC benefits.

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Authorized Person/Participant: _____ Date: _____

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MDHHS-5913 (3-21)

Forms with a signature or initials will not be editable once saved.

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Android

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Done

AUTHORIZATION TO RELEASE WIC INFORMATION
Michigan Department of Health and Human Services
WIC Program

Client Name _____ Family ID _____ Client Date of Birth _____

Client Address _____

City _____ Zip Code _____ Phone _____

I, (Authorized Person/Participant) _____ authorize Michigan WIC to release information contained in the WIC Client Record (anthropometric data, diet recommendations, breastfeeding information, etc.) for (Client Name(s)) _____ to the following physician(s): _____

Dr. Love _____

Authorization to release any of the following information must be initiated and dated in the appropriate section below

☒ Yes ☐ No I (Authorized Person/Participant) give Michigan WIC permission to share my communicable disease status (including HIV), information about my alcohol or drug abuse treatment history, and/or my mental health treatment history.

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7. Next tap the date box to type in the date.

iOS

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Done

AUTHORIZATION TO RELEASE WIC INFORMATION
Michigan Department of Health and Human Services
WIC Program

Client Name _____ Family ID _____ Client Date of Birth _____

Client Address _____

City _____ Zip Code _____ Phone _____

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Done

AUTHORIZATION TO RELEASE WIC INFORMATION
Michigan Department of Health and Human Services
WIC Program

Client Name _____ Family ID _____ Client Date of Birth _____

Client Address _____

City _____ Zip Code _____ Phone _____

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Dr. Love _____

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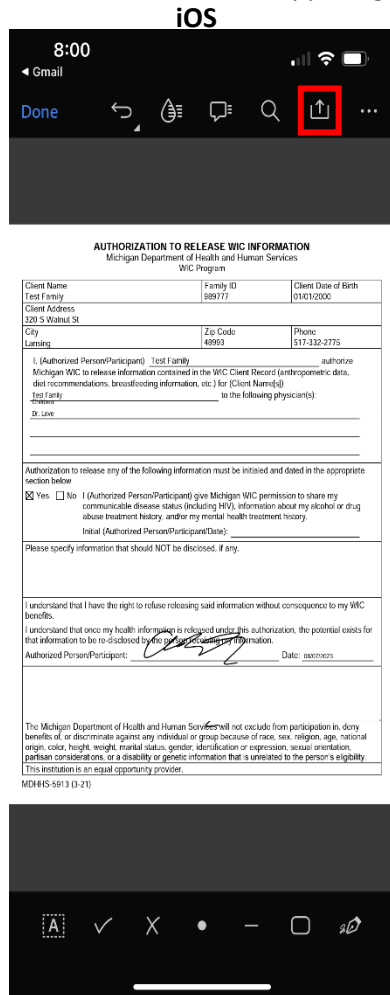
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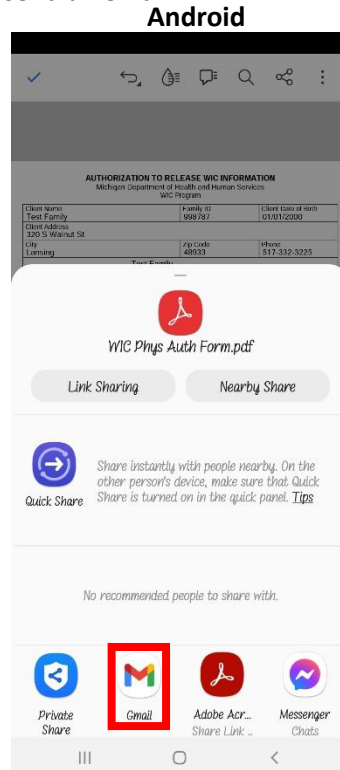
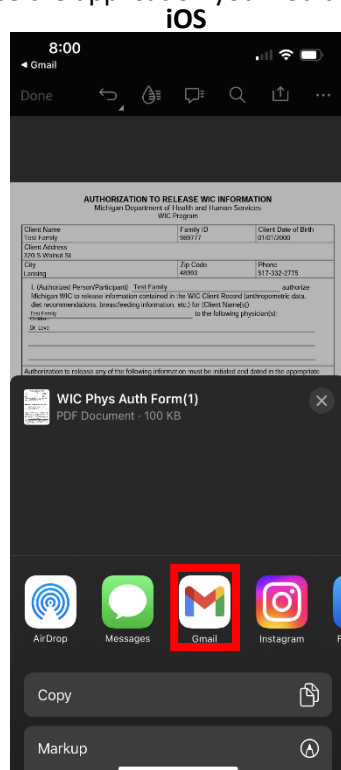
MDHHS-5913 (3-21)

A ✓ ✗ • □ — ↺

- Click the share button in the upper right corner of the screen and 'Send a copy'.

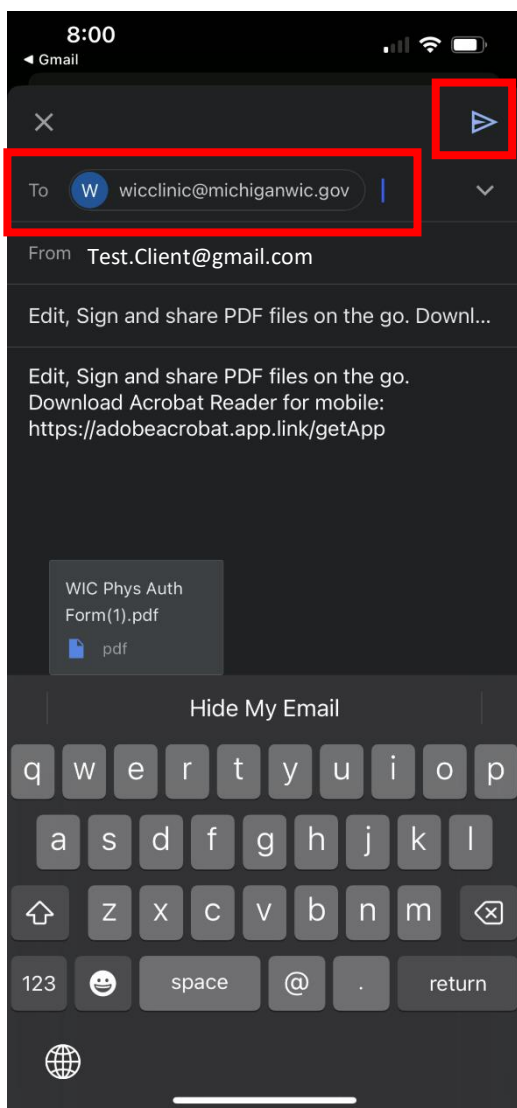


- Choose the application you would like to send an email.



10. Type your WIC Clinic's email in the address bar and send.

iOS



Android

