Michigan Department of Community Health

Jennifer M. Granholm, Governor
Janet Olszewski, Director

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Individual's Name (e.g. Beneficiary, Receipient, Patient, Consumer, etc.)	**Individual's Birthdate**
	/ /
Individual's I.D. Number (Medicaid, Medical Record, or other if applicable)	**Individual's Social Security Number**
	- -

I authorize the _____

to disclose the above-named individual's health information as described below.

The type and amount of information to be disclosed is as follows: (Include dates where appropriate)

I understand that this information may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex) and any other communicable disease. It may also include information about behavioral or mental health services, and referral or treatment for alcohol and drug abuse (as permitted by 42 CFR Part 2).

This information may be disclosed to and used by the following person or organization:

Name of Authorized Person/Organization

Address (Street)

Address (City, Zip Code)

( ) - **( ) -**

Phone Number: **Fax Number:**

This disclosure and use is for the following purpose(s):

(Note: The statement "at the request of the individual" is sufficient when the individual initiates an Authorization and does not, or chooses not to, state the purpose.)

I understand that if I give MDCH permission I have the right to change my mind and **revoke** it. This must be in writing to: Privacy Office, Michigan Department of Community Health, 320 S. Walnut, Lansing, Michigan 48913. I also understand that MDCH cannot take back any uses or disclosures already made with my permission.

Unless otherwise revoked, this authorization will expire on the following date, event or condition. If I fail to specify an expiration date, event or condition, this authorization will expire one year from the signature date:

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 ability to obtain treatment, payment for services, or eligibility for benefits.

By signing this Authorization, I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal privacy rules. I further understand I may request a copy of this signed authorization.

Printed Name of Individual or Legal Representative

Signature of Individual or Legal Representative **Date**

If signed by Legal Representative, Relationship to Beneficiary (A letter of authority may be requested)

Signature of Witness **Date**

MDCH USE ONLY

This authorization was revoked:

Signature **Date**

This authorization 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