AUTHORIZATION FOR RELEASE OF INFORMATION

Michigan Department of Health and Human Services

I, _____ authorize the Michigan Department of Health & Human Services (MDHHS) to release otherwise confidential information to Senator/Representative _____, _____ or his or her designee, related to my case record, unless otherwise restricted by state or federal law. The case record information for which I am providing this authorization includes:

Please provide a brief description of the issue.

MDHHS Programs needing information on (please check those that apply)

☐ Food Assistance	☐ Cash Assistance	☐ Medicaid
☐ State Emergency Relief	☐ State Disability	☐ Child Day Care
☐ Adult Services	☐ Other	

Constituent Information

Name	Case #	Phone Number
Address	City/Zip Code	

Constituent Signature	Date

Note: The Department is not able to share case-specific information on Children's Protective Services, Foster Care, Adoption or Child Support Cases.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Michigan Department of Health and Human Services

Directions: Type or Print all requested information, with exception of signatures on Page 2.

Individual's Name (Beneficiary, Recipient, Patient, Consumer, etc.)			Individual's ID Number (Medicaid, SSN, Other)
Street Address			Individual's Date of Birth
City	State	Zip Code	Phone Number

I AUTHORIZE THE MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES (MDHHS) TO SHARE MY HEALTH INFORMATION

List the amount or type of information you would like to share in the section below. For example, you can say all my health information or list certain types of information you would like to share.

Eligibility for services, services rendered, medical conditions, and claims.

MDHHS MAY SHARE MY HEALTH INFORMATION WITH THE FOLLOWING PERSON OR ORGANIZATION

Name of Person/Organization	
Street Address	
City, State, Zip Code	
Phone Number	Fax Number

MDHHS WILL SHARE MY HEALTH INFORMATION FOR THE FOLLOWING REASON

For example, to discuss my health care benefits or at the request of the individual.

At the request of the individual.

BY SIGNING THIS FORM, I UNDERSTAND THAT:

- I do not have to sign this authorization.
- My refusal to sign this authorization will not affect my ability to obtain treatment, payment for services, enrollment or eligibility for benefits.
- Information regarding behavioral and mental health services, substance use disorder treatments, and communicable diseases such as sexually transmitted diseases and human immunodeficiency virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS related complex) may be shared if I initial here or if I list this type of information above _____.
- If I authorize the release of substance use disorder treatment information, the recipient cannot re-disclose this information without my permission unless permitted under federal or state law.
- Other types of information shared under this authorization may be re-disclosed by the person or organization I identified above and may no longer be protected by federal or state law.
- I may change my mind and revoke (take back) this authorization at any time. To revoke this authorization, write to the MDHHS program that maintains your records and include a copy of the front of this form.
- Information that has already been shared based on this authorization cannot be taken back.
- I may request a copy of this signed authorization.
- If I have not previously revoked this authorization, **THIS FORM WILL EXPIRE ON** (list a date, event, or condition):

Date, Event or Condition (Authorization will expire one year from the signature date below if you leave this section blank.)

Signature of Individual or Legal Representative	Date
Name of Individual or Legal Representative	
Legal Representative's Relationship to Individual (i.e., Parent, Guardian, Patient Advocate, Authorized Representative, Power of Attorney. Documentation may be required.)	

MDHHS USE ONLY

This authorization was revoked

Signature	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.

AUTHORITY: This form is acceptable to the Michigan Department of Health and Human Services 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.