MATERNAL CONSENT TO RELEASE PROTECTED HEALTH INFORMATION

Michigan Department of Health and Human Services Maternal Infant Health Program

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 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 to by law.

I authorize the My Pregnancy Coach, Inc. (MIHP agency) to exchange information to other parties as specified below:

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

Name of Prenatal Care Provider	Date	Initialed by Beneficiary
Name of Other Parties with Whom Information may be Exchanged	Date	Initialed by Beneficiary

1. 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).
2. 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.
3. 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 MIHP agency that maintains my record if I decide to cancel it.
4. 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.
5. I understand that any uses or releases already made with my consent cannot be taken back.
6. I understand that I may request a copy of this signed consent.
7. I understand that this consent will expire at the end of MIHP services unless I cancel it before expiration of services.

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.

☐ 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 (Print)	Legal Representative Name if applicable (Print)	Legal Representative Relationship to Beneficiary

Signature of Beneficiary or Legal Representative	Date

Signature of MIHP RN or SW	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, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.