MDHHS-5645, MATERNAL CONSENT TO RELEASE PROTECTED HEALTH INFORMATION

Michigan Department of Health and Human Services (MDHHS)
Maternal Infant Health Program (MIHP)
(Revised 6-25)

SECTION 1

We care about your privacy. Only people who have both the need and the legal right may see your information. We will share your information with your medical provider and payor so that we can coordinate care. We may disclose your information without your permission when we are required by law to do so.

When information is shared, this may include all information that MIHP collects, such as:

1. Your MIHP Assessment Interview answers.
2. Other information you provide.
3. Information that another party provides.

Indicate with whom you want MIHP to exchange information with by identifying the parties below.

I authorize the MIHP agency to exchange information to other parties as specified below.

My health information may be exchanged with the following parties:

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

1. I understand that a separate release of information for records that contain treatment for alcohol and drug abuse (as permitted by MCL 330.1748, P.A. 258 of 1974 and 42 CFR Part 2) is required.
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.

Note: Verbal consent is not allowed to release protected health information.

SECTION 2 – SIGNATURE

Beneficiary Name (Print)	Legal Representative (If applicable) (Print)	Legal Representative Relationship to Beneficiary

Signature of Beneficiary or Legal Representative	Date

Signature of MIHP Staff	Date

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

MATERNAL CONSENT TO RELEASE PROTECTED HEALTH INFORMATION INSTRUCTIONS

Complete this form only if consent to share information with other health and social service agencies is desired.

These instructions are intended to clarify data fields. If you have additional questions, contact the MDHHS MIHP Team.

Explain how MIHP would share beneficiary's protected health information as described at the top of this form.

Authorizing Other Parties to Receive Protected Health Information (PHI)

- Insert the names of parties with whom PHI may be shared such as WIC, MDHHS, CMH, food bank, etc.
- Ask the beneficiary to verify each party with whom information may be shared by providing the date (in the second column) and beneficiary initials (in the third column). This must be done separately for each party. The beneficiary may not date and initial one party and draw arrows to indicate that the same date and initials also apply to other parties.
- Explain the seven numbered items beginning at the bottom of page 1 to the beneficiary.

Signatures Section

- Beneficiary Name: Print the name of the pregnant beneficiary.
- Legal Representative Name (If applicable) (Print): Print the legal representative's name, if this is applicable.
- Legal Representative Relationship to Beneficiary: Write "mother," "father," other relative (specify), "foster parent," or "guardian." If there is no legal representative, leave this field blank or write "NA."
- Signature of Beneficiary or Legal Representative and Date: The beneficiary or the legal representative (as defined above) must sign and document date of signature. The signature date can be the same date the Risk Identifier is administered or after if this consent was signed at a later date. If the beneficiary or legal representative printed name or a mark, initial.
- Signature of MIHP Staff: MIHP staff must sign and date. The consent form is completed once both signatures are secured. The date of record is the last signature date recorded.