INFANT 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 family's health care providers. This is 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 by law to do so.

I authorize the MIHP agency (My Pregnancy Coach) to exchange information from my Infant's MIHP record to other parties as specified below. This includes:

☐ My Infant's Protected Health Information
☐ My Protected Health Information

Information may be exchanged with the following parties:

Name of Infant's Medical Care Provider	Date	Initialed by Beneficiary
Name of my Medical Provider	Date	Initialed by Beneficiary
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 re-disclosure 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 then.

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.

Infant Beneficiary Name (Print)	Legal Representative Name (Print)	Legal Representative Relationship to Infant Beneficiary (Print)

Signature of Legal Representative	Date

Signature of MIHP RN or SW	Date

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

INFANT CONSENT TO RELEASE PROTECTED HEALTH INFORMATION INSTRUCTIONS

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

In the case of multiples, complete a separate consent form for each infant.

Explain to the legal representative 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)

- I authorize the MIHP agency (_____) to share my health information with other parties as specified below: Agency name is inserted here. Do not cross out the name of another agency and write in the name of your agency. This field may prepopulate.
- Check the first check box if the infant's PHI may be shared. Check the second check box if the legal representative's PHI may be shared.
  - If neither box is checked, skip to the last bullet in this section, which is in the middle of page 2.
  - If both boxes are checked, any information in the infant's chart may be shared with any of the parties listed in the grid.
  - If only the infant's box is checked, the legal representative's information may not be shared with any of the parties listed in the grid.
  - If both of the boxes are checked, but the legal representative does not want his or her PHI shared with all of the parties listed in the grid, the parties with whom it may not be shared must be clearly designated.
- In the grid on the second half of the page, insert the names of the parties with whom PHI may be shared:
  - Insert the infant's medical care provider's name on the first line. If the infant does not have a medical care provider at the time of MIHP enrollment, add the name to the form at a later date and ask the legal representative to date and initial it. If the infant's medical care provider changes during the course of care, add the name of the new provider to the "other parties with whom information may be exchanged" section of the grid and ask the legal representative to date and initial it. Also, document that the beneficiary is no longer seeing the first medical care provider to ensure that PHI is not sent to this party.
  - Insert the legal representative's medical care provider's name.
  - Insert the names of other providers on the remaining lines. You may prepopulate the grid with the names of the other providers to which beneficiaries are most likely to be referred (e.g., WIC, MDHHS, CMH, lactation consultant, food bank, Early On, etc.).
- Ask the legal representative to verify each party with whom information may be shared by providing the date (in the second column) and her initials (in the third column). This must be done separately for each party. She 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 legal representative.
- Ask the legal representative to check one of the boxes: I DO or I DO NOT consent to the release of protected health information as specified in this form. Do not prepopulate this field, unless you present

the legal representative with two separate forms, one checked “I DO” and one checked “I DO NOT.” If the legal representative does not consent to the release of protected information as specified in this form, you may still serve the infant.

Signatures Section

- Infant Beneficiary Name: Print the name of the infant beneficiary.
- Legal Representative Name: Print the name of the legal representative. This field must always be completed.
- If the mother is under 12 years of age, or is incapacitated and has a guardian, she is considered to be the infant’s legal representative, unless court action has been taken.
- Legal Representative Relationship to Infant Beneficiary: Write “mother,” “father,” other relative (specify), “guardian,” or “foster parent.”
- Signature of Legal Representative and Date: The legal representative (as defined above) must sign and document date of signature. The signature date cannot be after the date that the Risk Identifier is administered. If the beneficiary or legal representative cannot sign her name, ask them to sign their mark. Their printed name can be their mark.
- Signature of MIHP RN or SW: RN or SW must sign, with credentials, and document the date of signature. The signature date cannot be after the date that the Risk Identifier is administered.