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 (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 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 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 (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.

MATERNAL 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.

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)

- 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 another agency. This field may be prepopulated.
- In the grid on the second half of the page, insert the names of the parties with whom PHI may be shared:
    - Name of Prenatal Care Provider: Insert the prenatal care provider's name on the first line. If the beneficiary does not have a prenatal care provider at the time of MIHP enrollment, add the name to the form at a later date and ask the beneficiary to date and initial it. If the beneficiary changes prenatal care providers 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 beneficiary to date and initial it. Also, document that the beneficiary is no longer seeing the first prenatal care provider to ensure that PHI is not sent to this party.
    - Name of Other Parties with Whom Information May Be Exchanged: Insert the names of other providers on the remaining lines. 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, baby pantry, 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.
- Ask the beneficiary 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 presenting the beneficiary with two separate forms, one checked "I DO" and one checked "I DO NOT." Check the box for the beneficiary while discussing and completing this document. If the beneficiary or legal representative does not consent to the release of protected health information, as specified in this form, the beneficiary may still serve the beneficiary.

Signatures Section

- Beneficiary Name: Print the name of the pregnant beneficiary.
- Legal Representative Name if Applicable: Print the name of the legal representative if:
    - The pregnant beneficiary is under 12 years of age.
    - The pregnant beneficiary is 12 years of age or older and has a court-appointed guardian to make personal decisions such as medical care decisions.

  If there is not a designated legal representative, leave this field blank or write "NA."

- 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 cannot be after the date that the Risk Identifier is administered. If the beneficiary or legal representative printed name or a mark, please initial.
- 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.