CONSENT TO EXCHANGE HEALTH INFORMATION

IDENTIFYING INFORMATION				
Individual Name (Please Print)	Individual Identifier	Date of Birth	Last-4-Digits of SSN	Consent-ID YYJDT###

SIGNING THIS FORM WILL ALLOW YOUR HEALTHCARE PROVIDERS AND HEALTH PLANS TO EXCHANGE AND USE YOUR HEALTH INFORMATION TO ENSURE THE HIGHEST QUALITY OF COORDINATED CARE

I. "Who"

By signing this form, I voluntarily authorize the healthcare providers and health plans involved in my care and identified below, to communicate, disclose and otherwise share my healthcare information among and between themselves as identified in Section-II below (titled "Information That May Be Shared-"What"). The initiating Party is listed first.

1. Organization Names not Individuals
2. Core Provider – MCPN
3. Organization Names not Individuals
4. Others
5. Medicaid Health Plan – ICO
6.
7. PIHP, CMHSP
8.

Additional Providers and Health Plans can be added at the top of the Second Page

II. Information That May Be Shared - "What"

I authorize the healthcare providers and health plans involved in my care and identified in Section-I to exchange, disclose, and/or re-disclose to one another my medical information for which my express consent is required, including, if applicable **(1) alcohol and drug abuse records protected under 42-CFR part 2 of the Code of Federal Regulations, (2) mental health information protected under federal and state law, (3) information concerning communicable diseases and infections as defined in MCLA 333.5131, including sexually transmitted diseases, tuberculosis, HIV/AIDS, and any other medical information.** This consent applies to records relating to diagnosis, treatment, lab results, prescriptions, medication reviews, personal and demographic information. The information may be shared for the purpose identified in Section-III below.

III. Purpose Of The Authorized Disclosures – "Why"

The purpose of the disclosures authorized in this consent is to assist the above parties in properly diagnosing and treating my health conditions and in coordinating their services and to assist my healthcare providers and health plans in improving their services and processes.

IV. Term of Consent, Right to Revoke, Acknowledgements and Signature

Your choice on whether to sign this form will not affect your ability to get mental health or medical treatment, payment for treatment, health insurance enrollment or eligibility for benefits. I understand that I have the right to revoke this consent at any time except to the extent that action has been taken in reliance on it. Consent may be revoked in any manner allowed by law, including by signing the revocation on the second page of this form. **Unless I revoke this consent, it will automatically expire one year after the signature date.** I also understand that I have the right to refuse to sign this form; however, that will not prevent disclosure of my health information that may be disclosed under the law without my consent. To facilitate the exchange of information the healthcare providers and health plans may be supported by organizations that specialize in the exchange of healthcare information including: Health Information Organizations (HIOs) and Health Information Exchanges (HIEs).

Individual providing Consent Signature

Parent/Guardian/Authorized Representative Signature

If Signed – Indicate Relationship:

☐ *Parent* ☐ *Guardian* ☐ *Authorized Representative*

Date Signed:

☐ **Individual Provided Copy**

DRAFT

V. Additional Healthcare Providers and Health Plans **–** Continued from Previous Page

9. Next Healthcare Provider
10. Next Healthcare Provider
11. Next Healthcare Provider
12. Next Healthcare Provider
13. Medicaid Health Plan – ICO
14. Core Provider – MCPN

Notes to the Individual providing Consent

Please contact your local Primary Care Physician, Case Manager or other primary healthcare contact to add, revoke, or manage your Consents to Share Healthcare Information.

The organization you are working with to revoke consent can only administer the change for consents where they are identified as a party.

Revoking My Consent to Exchange Information

This consent is subject to revocation at any time. I understand that prior to this date, information may have been shared with the individual and/or organization named above, and that treatment may have been provided based upon this information. Note: The organization managing this revocation is only able to revoke those consents within its control.

I revoke my consent(s) to share information by completing the following section:

As of _____(Date)_____ I hereby revoke the following Consent(s) to share my healthcare information:

____ Any Consent containing any of the following parties: "*[Typically the organization that collects or manages the consent]"*

_____, _____

_____, _____

_____, _____

☐ - Any Consent for ALL parties indicated in Section I

Note: The organization you are working with to revoke consent can only administer the change for consents where they are identified as a party in the exchange.

_____ _____ _____

Individual/Guardian Signature | Printed Name | Date Signed

Notes to Staff

Signature – For Minors ages 14-18, who are enrolled in substance use disorder treatment, this consent should be signed by the Minor and Parent/Guardian