Provider Instructions Consent to Share Form

These **instructions** will help explain the **Consent to Share Behavioral Health Information Form** shown below. *All steps are listed for filling out this form correctly.*

Section 1:

Be sure to include individual's **full name, date of birth, and the date signed (same date as signature in Section 4)**

Section 2a:

Ask what **organizations, providers, doctors, or family members** the individual would like to **give consent to share** their behavioral healthcare information with. ***This allows information to be shared among all those listed as necessary.***

Be specific. This list should include:

- **NorthCare Network**
- **Upper Peninsula Health Plan**
- **CMHSP**
- **Doctor's name**
- **Guardian's name**

Remember, it is ultimately the individual's choice of whom to grant consent and what information to share.

CONSENT TO SHARE BEHAVIORAL HEALTH INFORMATION

Michigan Department of Health and Human Services

Use this form to give or take away your consent to share information about your:

- Mental and behavioral health services. This will be referred to as "behavioral health" throughout this form.
- Diagnosis, referral, and treatment for an alcohol or substance use disorder. This will be referred to as "substance use disorder" throughout this form.

This information will be shared to help diagnose, treat, manage, and pay for your health needs.

Why This Form Is Needed

When you receive health care, your health care provider and health plan keep records about your health and the services you receive. This information becomes a part of your medical record. Under state and federal laws, your health care provider and health plan do not need your consent to share most types of your health information to treat you, coordinate your care, or get paid for your care. But they may need your consent to share your behavioral health or substance use disorder records.

Instructions

- To **give** consent, fill out Sections 1, 2, 3, and 4.
- To **take** away consent, fill out Sections 5.
- Sign the completed form, then give it to your health care provider. They can make a copy for you.

Section 1: About You

First Name	Middle Initial	Last Name	Date of Birth	Date Signed
John	L	Doe	10/02/1940	01/09/2020

Section 2: Who Can See Your Information and How They Can Share It

Section 2a: Sharing Information Between Individuals and Organizations

Let us know who can see and share your behavioral health and substance use disorder records. You should list the specific names of health care providers, health plans, family members, or others. They can only share your records with people or organizations listed below.

1. [Your] Community Mental Health Agency
2. NorthCare Network
3. UPHP
4. Dr. Sam Smith
5.
6.

IMPORTANT: Be sure individual and provider both have a signed copy of this form, MDHHS-5515, Version 5.0 (Rev. 12-18).

Provider Instructions Consent to Share Form

Additional guidance on completing this consent can be found at:
www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_58005-343686--,00.html

Section 2b: Sharing Information Electronically

Health information exchanges or networks share records back and forth electronically. This type of sharing helps the people involved in your health care. It helps them provide better, faster, safer, and more complete care for you. Your health care provider and health plan may have already listed these organizations below.

Choose only one option:

- ☐ Share my information through the organizations listed below. This information will be shared with the individuals and organizations listed under Section 2a.
- ☐ Do not share my information through the organizations listed below.
- ☐ Share my information through the organizations listed below with all of my past, current, and future treating providers. If I choose this option, I can request a list of providers who have seen my records.

For Health Care Provider or Health Plan Use Only. List all health information exchanges or networks:

1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

Section 3: What Information You Want to Share

Choose one option:

- ☐ Share **all** my behavioral health and substance use disorder records. This does not include "psychotherapy notes."
- ☐ Share **only** the types of behavioral health and substance use disorder records listed below. For example, what I am being treated for, my medications, lab results, etc.

Check only one box

1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

Section 4: Your Consent and Signature

Read the statements below, then sign and date the form.

By signing this form below, I understand:

- I am giving consent to share my behavioral health and substance use disorder records. This includes referrals and services for alcohol and substance use disorders, but other information may also be shared.
- I do not have to fill out this form. If I do not fill it out, I can still get treatment, health insurance or benefits. But, without this form, my provider or health plan may not have all the information needed to treat me.
- My records listed above in Section 3 will be shared to help diagnose, treat, manage, and pay for my health needs.

Section 2b:

This section pertains to sharing records **electronically through** the Health Information Exchange(s) (HIE) listed, with individuals and organizations noted in Section 2a, when requested. At this time NorthCare Network does not share information through an HIE; this will default to NA.

Section 3:

Explain each choice and the option to limit what is shared (e.g., only share Individual Plan of Service, or IPOS.)

Section 4:

Review **each bullet** with individual. Make sure everything is clear and that individual understands what consent is being given.

IMPORTANT: A Witness is required to sign the consent only if an individual is not able to sign their name or if they sign with an "X".

Provider Instructions Consent to Share Form

Individuals may withdraw their consent at any time.
Withdrawal of consent may be written or given verbally.

NOTE: Psychotherapy notes are notes that a mental health professional takes during a conversation with a patient, separate from a patient's medical and billing records. **HIPAA** does not allow the provider to make most disclosures about psychotherapy notes about you without your authorization.[1]

1) https://www.hhs.gov/hipaa/for-professionals/faq/558/does-hipaa-permit-a-covered-entity-to-disclose-psychotherapy-notes-to-an-hio/index.html

(cont. from pg.2)

- My records may be shared with the people or organizations as stated in Section 2.
- Other types of my health information may be shared along with my behavioral health and substance use disorder records. Under existing laws, my health care provider and health plan do not need my consent to share most types of my health information to treat me, coordinate my care or get paid for care.
- This form does not give my consent to share "psychotherapy notes".
- I can remove my consent to share behavioral health and substance use disorder records at any time. I understand that any records already shared because of past approval cannot be taken back. I should tell all individuals and organizations listed on this form if I remove my consent.
- I have read this form. Or it has been read to me in a language I can understand. My questions about this form have been answered. I can have a copy of this form.
- This signature is good for **1 year** from the date signed. Or I can choose an earlier date or have it end after the event or condition listed below. (For example, at the end of my treatment.)
  Date, event, or condition: _____

State your relationship to the person giving consent and then sign and date below:

☐ Self
☐ Parent (Print Name) _____ **Check box to indicate relationship to individual**
☐ Guardian (Print Name) _____
☐ Authorized Representative (Print Name) _____

Signature **Signature of person identified above**	Date **Date person signed**
Witness Signature (If Appropriate) **Witness signature and date**	Date

Please read **Witness footnote** on page 2.

TAKE AWAY YOUR CONSENT
Complete Section 5 if you no longer want to share your records listed above in Section 3.

Section 5: Fill out only if an individual no longer wants their information shared as stated in consent above.

Section 5: Who Can No Longer See Your Information
I no longer want to share my records with those listed in Sections 2a and 2b. I understand any information already shared because of past approval cannot be taken back.

State your relationship to the person withdrawing consent, then sign and date below.

☐ Self
☐ Parent (Print Name) _____ **Check box to indicate relationship to individual**
☐ Guardian (Print Name) _____
☐ Authorized Representative (Print Name) _____

NOTE: If an individual wants to partially withdraw consent, e.g., for only one provider listed, it is recommended that the ***entire consent be withdrawn***. **A new consent form should be signed for those providers that the individual continues to want to share information with.** ***Encourage the individual to inform providers they have changed their consent form.***

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NOTE: The section below titled **"Other Information for Health Care Providers and Health Plans"** **is to be completed for the consent and is not specific for a verbal withdrawal of consent.**

Signature	Date
Signature of person identified above	**Date person signed**
Witness Signature (If Appropriate)	Date
Witness signature and date	

FOR HEALTH CARE PROVIDER OR HEALTH PLAN USE ONLY

Verbal Withdrawal of Consent

☐ The individual listed above in Section 1 has taken away his/her consent.

List the individual who requested the withdrawal below, then sign and date below.

☐ Individual listed above in Section 1.

☐ Parent (Print Name) _____

☐ Guardian (Print Name) _____

☐ Authorized Representative (Print Name) _____

Signature of Person Who Received the Verbal Withdrawal	Print Name	Date
Signature of person receiving consent	**Print name clearly and date**	

Other Information for Health Care Providers and Health Plans

This form cannot be used for a release of information from any person or agency that has provided services for domestic violence, sexual assault, stalking, or other crimes. See the FAQ for providers and other organizations at michigan.gov/bhconsent.

Additional Identifiers (Optional)

Medicaid Last 4 of the Social Security Number

Form Copy (Optional, Choose One Option) **Check only one box**

☐ The individual in Section 1 **received** a copy of this form.

☐ The individual in Section 1 **declined** a copy of this form.

AUTHORITY:	This form is acceptable to the Michigan Department of Health and Human Services as compliant with 42 CFR Part 2, PA 258 of 1974 and MCL 330.1748 and PA 368 of 1978, MCL 333.1101 et seq. and PA 129 of 2014, MCL 330.1141a.
COMPLETION:	Is Voluntary, but required if disclosure is requested.

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.

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Previous edition obsolete.

Use this section when an individual or authorized representative **revokes consent verbally.**

This signature is for the person receiving verbal withdrawal of consent.

For Elmer Users - Optional identifiers will not print unless the "Hide Identifiers" checkbox is unchecked.

Indicate whether the individual received or declined a copy of amended consent form.

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