Release of Information

(Please Print)

Patient's Name *First* *Last*	Birthdate

Why is this form needed

When clients receive health care, their health care provider and health plan keep records about their health and the services they receive. This information becomes a part of their medical record. Under state and federal laws, the health care provider and health plans do not need a client's consent to share most types of their health information to treat the client, coordinate their care, or get paid for their care. However, Starr Commonwealth may need the client's consent to share their behavioral health or substance use disorder records.

By signing this form below, I understand:

1. I am giving consent to share the client's 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
2. I do not have to fill out this form. If I do not fill it out, the client can still get treatment, health insurance or benefits. But, without this form, the provider or health plan may not have all the information needed to treat the client
3. The client record listed below will be shared to help diagnose, treat, manage and pay the client's health needs.
4. Clients records may be shared with the people or organizations listed in section 2a.
5. Other types of client's health information may be shared along with their behavioral health and substance use disorder records. Under existing laws, their health care provider and health plan do not need my consent to share most types of my health information to treat the client, coordinate their care or get paid for their care.
6. This form does not give my consent to share the client's **"Psychotherapy Notes".**
7. I can remove my consent to share the client's behavioral health and substance use disorder records at any time. I understanc 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 parental/legal guardian consent.
8. 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.
9. 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 the client's treatment.)

For office use only *:*
Use this form to give or take away consent to share information about the Client's:
•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 Client's health needs.

To give consent to release information complete sections 1,2, and 3:

<table>
<tr><td>Section 1:

I, ____ Authorize Starr Commonwealth to release information regarding my child’s Mental and Behavioral Health Services.

I, ____ Authorize Starr Commonwealth to release information regarding my child’s Diagnosis, referral and treatment for an alcohol or substance use disorder.</td><td></td></tr>
<tr><td>Patient’s Signature (or legal guardian, if applicable)
X____</td><td>Date ___________________</td></tr>
<tr><td>Relationship to client as authorizer of this form
X____</td><td>Date ___________________</td></tr>
<tr><td>Office: Witness X____</td><td>Date ___________________</td></tr>
</table>

Section 2a: Sharing Information Between Individuals and Organizations

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

1. ____ 4. ____
2. ____ 5. ____
3. ____ 6. ____

Section 2b: Sharing Information Between Individuals and Organizations

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

Choose only ONE option:

□ Share Client's information through the organizations listed below. This information will be shared with the individuals and organizations listed above under Section 2a.

□ Do not share Client's information through the organizations listed below.

□ Share Client's information through the organizations listed below with all of their past, current, and future treating providers. If this option is chosen, a request for a list of providers who have seen this person's records can be provided.

For Office us only:	
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

□ Share **ALL** 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 is specifically being treated, medications, lab results, etc.

1. ______________________________	4. ______________________________
2.______________________________	5.______________________________
3. ______________________________	6.______________________________

To Decline Consent to Release Information, fill out section 5:

Section 5: I, ______________________________ **Decline** to give Starr Commonwealth consent to share information regarding my child's Mental and Behavioral Health Services. I, ______________________________ **Decline** to give Starr Commonwealth consent to release information regarding my child's Diagnosis, referral and treatment for an alcohol or substance use disorder.	
Patient's Signature (or legal guardian, if applicable) **X**______________________________	Date ______________
Relationship to client as authorizer to withdraw consent **X**______________________________	Date ______________
Office: Witness **X**______________________________	Date ______________

FOR HEALTH CARE PROVIDER OR HEALTH PLAN USE ONLY
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
Form Copy (Optional, Choose One Option) □ The individual in Section 1 **Received** a copy of this form. □ The individual in Section 1 **Declined** a copy of this form.
Last 4 of the Social Security Number (**Optional)**

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.
Starr Commonwealth 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.

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) Legal Guardian (Print Name)Authorized Representative (Print Name)

Information to Release to Contact
☐ Appointment ☐ Financial/Billing ☐ Pharmacy Pick-up ☐ Emergency Information ☐ Lab Results

Contact Name/Relationship	Contact Address	City/State/Zip Code

Information to Release to Contact Please check all that apply below
☐ Appointment ☐ Financial/Billing ☐ Pharmacy Pick-up ☐ Emergency Information ☐ Lab Results

Contact Name/Relationship	Contact Address	City/State/Zip Code

Information to Release to Contact Please check all that apply below
☐ Appointment ☐ Financial/Billing ☐ Pharmacy Pick-up ☐ Emergency Information ☐ Lab Results

I authorize Starr Commonwealth to leave messages on the answering machine(s) at my contact number(s).
☐ Y ☐ N

I give my permission for my provider(s) with Starr Commonwealth to communicate {orally or written (i.e. summary letter)} with the following individual(s) in regard to:

☐ Examination ☐ Diagnosis ☐ My Treatment ☐ Specific Purpose:______________________________	Contact Name:
	Contact Name:

By signing below, I authorize Starr Commonwealth to release information concerning me, my minor child, or legal charge as indicated above. I understand that I may revoke this consent to release confidential information at any time with written consent, but that it will not affect any communic

Patient's Signature (or legal guardian, if applicable) **X** ____