AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Michigan Department of Human Services

Grantee Name				
Case Number		Client ID Number		
Patient's Name				
Male ☐	Female ☐	Patient's Date of Birth		
County	District	Section	Unit	Specialist
Specialist Name				
Telephone Number/ext.				

Patient's Name	Male ☐	Female ☐	Date of Birth

I authorize you to disclose the above-named individual's health information as described below. The type and amount of information to be disclosed is as follows:

REQUESTED INFORMATION:

- ☐ MEDICAL RECORDS: Physical examinations and clinical evaluations including any information relative to HIV, ARC or AIDS if applicable. Treatment for any physical and/or emotional illness including drug or alcohol abuse. Medical records, including admitting histories, discharge summaries, psychiatric or psychological reports, IQ scores, laboratory reports, test results, diagnosis, complications, progress notes, medications, workshop evaluations, training reports, treatment plans, prognosis, recommendations and current status.
- ☐ EDUCATION INFORMATION: Copies of educational tests or evaluations, including individualized education programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.
- ☐ Information created within 12 months after the date this authorization is signed, as well as past information.
- ☐ Provider ID #
- ☐ Other (Specify):

I understand that this information may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex) and any other communicable disease. It may also include information about behavioral or mental health services, and referral or treatment for alcohol and drug abuse (as permitted by 42 CFR Part 2).

This information may be disclosed to and used by the following:

_____ The Social Security Administrative and the State Agency (Department of Human Services – Disability Determination Services authorized to process my case, including contract copy services and doctors or other professionals consulted during the process.

_____
Address (Street)

_____
Address (City, State, Zip Code)

( ) _____ ( ) _____
Phone Number Fax Number

This disclosure and use is for the following purpose(s): Determining my eligibility for benefits including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability and whether I can manage such benefits.

☐ Determining whether I am capable of managing benefits ONLY (check only if this applies).

To establish initial or continued eligibility for:

☐ MEDICAID ☐ SSI/SSB ☐ SDA ☐ OTHER (specify): _____

(NOTE: The statement "at the request of the individual" is sufficient when the individual initiates an Authorization and does not, or chooses not to, state the purpose.)

This authorization is good for 12 months from the date signed.

- I authorize the use of a copy (including an electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties.
- I may write to SSA or DHS and my sources to revoke this authorization at any time.
- SSA and DHS will give me a copy of this form if I ask. I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- I have read both pages of this form and agree to the disclosures above from the types of sources listed.

I understand that if I give DHS permission, I have the right to change my mind and **revoke** it. This must be in writing to _____ County Department of Human Services. I also understand that DHS cannot take back any uses or disclosures already made with my permission.

I understand that authorizing the disclosure of this health information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.

By signing this Authorization, I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal privacy rules. I further understand I may request a copy of this signed authorization.

Printed Name of Client or Legal Representative

Signature of Client or Legal Representative or Guardian **Date**

If signed by Legal Representative, Relationship to Client (a letter of authority may be requested.)

Address **Phone**

Signature of Witness **Date**

Signature of Second Witness (if needed) **Date**

DHS USE ONLY

This authorization was revoked:

Signature **Date**

AUTHORIZATION:

This authorization is valid only for the purpose, information, agencies and persons cited above. This information release authorization has been prepared in accordance with the authority specified below:

- 42 CFR, part 2, subpart C, Section 2.31, as revised August 10, 1987
- Title 20 CFR 404, 1512 and Title 20 CFR 416.912
- Michigan Public Act 368 of 1978, as amended
- Michigan Public Act 488 of 1988, effective March 30, 1989

This authorization form is acceptable to the Michigan Department of Human Services as compliant with HIPAA privacy regulations 45 CFR Parts 160 and 164 as modified August 14, 2002.