MICHIGAN MEDICINE

Authorization for the Release/Disclosure of Substance Use Disorder Information

MRN:
NAME:
BIRTHDATE:
CSN:

Information disclosed pursuant to this consent must be accompanied by the notice prohibiting re-disclosure.

Part 1. This consent is voluntary. I am giving permission to share my substance use disorder information, including but not limited to referrals and services for alcohol and substance use disorders.

Patient Name: ______________________________ Maiden/AKA: ______________________ Date of Birth: __________

Street Address: ____ MRN (optional): _________________

City/State/Zip: ____ Telephone #: _________________________

Email Address: ____

Part 2. I am the patient, or the legally authorized representative of the patient listed above and authorize Michigan Medicine to disclose (verbally, electronically, or any other method) my substance use disorder information and any other pertinent information that may be necessary to disclose with the individuals and organizations listed below (Use an additional consent form if additional individuals or organizations need to be listed). **Insurance information below *must* be completed for billing.**

Health Care Providers **(Purpose of Disclosure: Treatment)**	**Insurance Company/Companies/3rd Party Payer(s)** **(Purpose: Billing, Coordination of Care, Care Management, etc.). Insurance information below must be completed for billing."**
☐ My health care providers listed below: 1.____ 2.____ 3.____ 4.____ 5.____ 6.____	☐ Medicare ☐ Medicaid ☐ Insurance Company/Companies listed below: Name: ____ Name: ____ Name: ____ Name: ____
Pharmacy/Pharmacies **(Purpose of Disclosure: Medication Prescribing)**	**Other Individual(s) or Organization(s)*** **Purpose (explain):** ________________________________ **From Dates:** ___/___/_______ **to** ___/___/_______ **(mm/dd/yyyy) (mm/dd/yyyy)**
☐ Surescripts® and any/all pharmacies to which I ask Michigan Medicine to send my prescription medication(s) for substance use disorder through electronic prescribing method, now and in the future. Note: If this box is not checked, the patient must take the written prescription(s) for substance use disorder to a pharmacy him/herself.	☐ Name:______________________________________ ☐ Name:______________________________________ ☐ Name:______________________________________ ☐ Name:______________________________________ *Note: This form is sufficient to authorize verbal communications with "Family and Friends" to assure compliance with 42 CFR Part 2 and other applicable state or Federal laws (e.g. HIPAA).

Part 3. Information to be shared:

Choose one of the options below to let us know what information can be shared.

☐ Share all of my behavioral health and substance use disorder information (e.g., diagnoses, medications, test results, substance use history, summaries of care, clinical notes, discharge summary, social support, living situation, billing information, etc.).

☐ Share most of my behavioral health and substance use disorder information. Do NOT share the following *(list the types of information you do NOT want shared below):*

1. _____________________________________ 2. _____________________________________
3. _____________________________________ 4. _____________________________________

☐ Only share the following types of behavioral health and substance use disorder information *(list only the types of information you want shared below):*

1. _____________________________________ 2. _____________________________________
3. _____________________________________ 4. _____________________________________

Part 4: Your permission and signature

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

By signing this form below, I understand:

- I am giving permission to share my substance use disorder information. This includes but is not limited to referrals and services for alcohol and other substance use disorders.
- My information will be shared to help diagnose, treat, manage, and pay for my health needs.
- My information may be shared with the individuals or organizations listed in part 2.
- I do not have to fill out this form. If I don't fill it out, I can still get treatment, health insurance or benefits. But, without this form, providers may not have all of the information needed to treat me, and I will be responsible for payment of services if I do not authorize disclosure to my insurance company(ies) so that Michigan Medicine can bill insurance.
- Other types of my health information may be shared along with my substance use disorder information. Under the Health Insurance Portability and Accountability Act (HIPAA) and Michigan Mental Health Code, my health care provider does not need my permission to share most types of my health information to treat me, coordinate my care or get paid for care.
- I can revoke (cancel) my permission, either in full or part of it, at any time. I understand that any information already shared because of past approval cannot be taken back. I should tell all individuals and organizations listed on this form if I revoke my permission.
- I have read this form or have had it 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 one year from the date signed unless I choose a different date or want it to end after a certain event or condition (for example, at the end of my treatment, upon my death, etc.)
  Write the date, event or condition below.

  End date, event, or condition:

Revoking (cancelling) authorization: I may revoke (cancel) this consent at any time. Revocations (cancellations) must be made in writing and sent to Michigan Medicine Revenue Cycle Mid Service (HIM) Release of Information (ROI) Unit at: 3621 S. State Street 700 KMS Place, Bay 11 - Mid Service, Ann Arbor MI 48108-1633, Fax: (734) 936-8571. Revocations (cancellations) will not apply to information that already has been released. If this authorization was obtained as a condition of providing insurance coverage, the authorization will not apply to my insurance company to the extent the law provides my insurer with the right to contest a claim under the policy, or the policy itself.

Note: Disclosure of information must be accompanied by a notice prohibiting re-disclosure. However, once information has been disclosed, Michigan Medicine can no longer protect it from and is not liable for further disclosure by individual(s) or organization(s) to whom disclosure was made pursuant to this consent.

____ ______/______/___________

Signature of Patient or Legally Authorized Representative (if patient is a minor or unable to sign.) **DATE** (mm/dd/yyyy)

____

Printed Name of Legally Authorized Representative (if patient is a minor or unable to sign)

Relationship to Patient: ☐**Spouse** ☐**Parent** ☐**Next-of-Kin**
☐**Legal Guardian** ☐**DPOA for Healthcare** (must attach proof of DPOA-HC)

Additional Information Regarding Your Request

Requesting medical records on behalf of another person

If you are consenting for disclosure for someone other than yourself, you may be required to provide additional documentation to show that you have a legal right to provide the consent. Examples of these documents include Letters of Representation, Guardianship Papers, etc. Please contact the Release of Information Unit at (734) 936-5490, to determine the documentation that will be required to process your request.