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| AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION – NEWBORN SCREENING |
| Michigan Department of Health and Human Services |
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| **Directions:** Type or print all requested information, with the exception of signatures on page 2. |
| Individual’s Name (Beneficiary, Recipient, Patient, Consumer, etc.) | Individual’s ID Number (Medicaid, SSN, Other) |
|       |       |
| Street Address | Individual’s Date of Birth |
|       |       |
| City | State | ZIP Code | Phone |
|       |    |       |       |
| **I AUTHORIZE THE FOLLOWING PERSON/ORGANIZATION TO SHARE MY HEALTH INFORMATION WITH THE MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES (MDHHS):** |
| Name of Person/Organization |
|       |
| Street Address |
|       |
| City, State, ZIP Code | Phone Number | Fax Number |
|       |    -   -     |    -   -     |
| **HEALTH INFORMATION TO BE SHARED:**List the amount or type of information you would like to share in the section below.For example, you can say all my health information or list certain types of information you would like to share. |
|  | A full circle, newborn dried blood spot from the person named at the top of this form. |  |
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| **MY HEALTH INFORMATION WILL BE SHARED FOR THE FOLLOWING REASON:**For example, to discuss my health care benefits or at the request of the individual. |
|  | The dried blood spot will be used in a research study to help increase the precision of  |  |
|  | newborn screening and diagnosis of MPS disorders. |  |
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| **By signing this form, I understand that:** |
| * I do not have to sign this authorization and my refusal to sign this authorization will not affect my ability to obtain treatment, payment for services, enrollment, or eligibility benefits.
* **Information regarding behavioral and mental health services, substance use disorder treatments, and communicable diseases such as sexually transmitted diseases and human immunodeficiency virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS related complex) may be shared if I initial here or if I list this type of information above \_\_\_\_\_\_\_\_.**
* If I authorize the release of substance use disorder treatment information, the recipient cannot re-disclose this information without my permission unless permitted under federal or state law.
* Other types of information shared under this authorization may be re-disclosed by the person or organization I identified above and may no longer be protected by federal or state law.
* I may change my mind and revoke (take back) this authorization at any time. To revoke this authorization, write to the MDHHS program that maintains your records and include a copy of page 1 of this form.
* Information that has already been shared based on this authorization cannot be taken back.
* I may request a copy of this signed authorization. If I have not previously revoked this authorization, it will expire on (list a date, event or condition):
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|  |  |  |
|  | Authorization will expire one year from the signature date if you leave this section blank. |  |  |

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| Signature of Individual or Legal Representative | Date (Month/Day/Year) |
|  |       |
| Name of Individual or Legal Representative |
|       |
| Legal Representative’s Relationship to Individual(i.e., parent, guardian, patient advocate, authorized representative, power of attorney. Documentation may be required.) |
|       |
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| **AUTHORIZED PERSON/ORGANIZATION USE ONLY** |
| This authorization was revoked: |  |
| Signature | Date (Month/Day/Year) |
|  |       |
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| 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. |
| **AUTHORITY:** This form is acceptable to the Michigan Department of Health and Human Services as compliant with HIPAA privacy regulations, 45CFR Parts 160 and 164 as modified August 14, 2002.**COMPLETION:** Is voluntary, but required if disclosure is requested |