MDHHS-5924, AUTHORIZATION FOR RELEASE OF INFORMATION

Michigan Department of Health and Human Services (MDHHS)

(Revised 7-24)

SECTION 1 - CONSTITUENT INFORMATION

Name	Case Number	Phone Number
Street Address	City/Zip Code	

Email Address (by providing your email address, you agree to potentially receive confidential information by way of email communications).

Constituent Signature	Date

NOTE: The Department is not able to share case-specific information on Children's Protective Services, Foster Care, Adoption or Child Support Cases.

SECTION 2

I authorize the Michigan Department of Health and Human Services (MDHHS) to release otherwise confidential information, related to my case record, unless otherwise restricted by state or federal law to Senator/Representative or his or her designee **Winnie Brinks.**

The case record information for which I am providing this authorization includes:

Provide a brief description of the issue, including the names of MDHHS programs involved in the issue.

SECTION 3

MDHHS Programs needing information on (check those that apply)

- ☐ Food Assistance
- ☐ Cash Assistance
- ☐ Medicaid
- ☐ State Emergency Relief
- ☐ State Disability
- ☐ Child Day Care
- ☐ Adult Services
- ☐ Other

SECTION 4 - AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

(Type or print all requested information, with exception of signatures on page 2).

Individual's Name (Beneficiary, Recipient, Patient, Consumer, etc.)

Individual's ID Number (Medicaid, SSN, Other)	Individual's Date of Birth	Phone Number
Street Address	City/Zip Code	

Email Address (by providing your email address, you agree to potentially receive confidential information by way of email communications).

SECTION 5

I authorize the Michigan Department of Health and Human Services (MDHHS) to share my health information, including eligibility for services, services rendered, medical conditions, and claims.

SECTION 6 - MDHHS WILL SHARE MY HEALTH INFORMATION TO DISCUSS MY HEALTH BENEFITS AT THE REQUEST OF THE INDIVIDUAL

Office of Senator/Representative and their staff
Winnie Brinks

SECTION 7 - BY SIGNING THIS FORM, I UNDERSTAND THAT:

- I do not have to sign this authorization.
- My refusal to sign this authorization will not affect my ability to obtain treatment, payment for services, enrollment or eligibility for 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 the front 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, **THIS FORM WILL EXPIRE ONE YEAR FROM THE DATE WRITTEN BELOW.**

Signature of Individual or Legal Representative | Date

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.)

SECTION 8 - MDHHS USE ONLY (This authorization was revoked)

MDHHS Signature | Date

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

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.