

Michigan Department of Corrections
Consent to Share Behavioral Health Information /
Release of Information - FAQ

What is a Consent to Share Behavioral Health Information / Release of Information (ROI)?

Under the Federal Health Insurance Portability and Accountability Act (HIPAA) and the Michigan Mental Health Code, covered entities may share most types of health information for purposes of payment, treatment, and coordination of care. However, other federal and Michigan laws require that providers receive specialized consent to share the following types of health information: information about behavioral health or mental health services that are provided by the Michigan Department of Health and Human Services, a Community Mental Health Service provider, or an entity under contract with the Michigan Department of Health and Human Services or a Community Mental Health Service provider, referrals and treatment for a substance use disorder.

The Michigan Department of Health and Human Services has created MDHHS-5515 for sharing these types of information, as required under Public Act 129 of 2014. For more information about this form, see www.michigan.gov/bhconsent.

What is 42 CFR Part 2?

42 CFR Part 2 are Federal Regulations governing the confidentiality of drug and alcohol abuse treatment records. For entities to coordinate with each other and disclose information, a signed release must be obtained from the person served.

Who signs the ROI if the person has a guardian?

The guardian must sign the release of information and we also ask for the person served to sign the ROI as well.

What type of signatures can be accepted?

The ROI must be signed with a physical signature, an electronic signature obtained through a digital signature pad, or an electronic signature that was obtained/verified by an electronic agreement system (i.e. DocuSign). Signatures, that were added through a (i.e. Word Document) font, cannot be accepted.

Which sections of the MDHHS-5515 ROI need to be filled out?

Section 1: Complete the full “About You” section regarding the person, whose information is supposed to be disclosed.

Section 1: About You				
First Name	Middle Initial	Last Name	Date of Birth	Date Signed

Section 2a: Includes the names of entities, which can communicate with each other regarding the individual. If the person is in a residential treatment setting, prison, jail, etc., additional entities can be added.

Section 2a: Sharing Information Between Individuals and Organizations	
Let us know who can see and share your behavioral health and substance use disorder records. You should list the specific names of health care providers, health plans, family members, or others. They can only share your records with people or organizations listed below.	
1. <u>Oakland Community Health Network</u>	5. <u>Pontiac Probation Office</u>
2. <u>All Oakland Community Health Network SUD Providers</u>	6. <u>Pontiac Parole Office</u>
3. <u>All Oakland Community Health Network Behavioral Health Providers</u>	7. <u>Troy Probation Office</u>
4. <u>Rise Center</u>	8. _____

Section 2b: Select what information can be shared amongst the providers listed in section 2a.

Section 2b: Sharing Information Electronically
Health information exchanges or networks share records back and forth electronically. This type of sharing helps the people involved in your health care. It helps them provide better, faster, safer, and more complete care for you. Your health care provider and health plan may have already listed these organizations below.
Choose only one option:
<input type="checkbox"/> Share my information through the organizations listed below. This information will be shared with the individuals and organizations listed under Section 2a.
<input type="checkbox"/> Do not share my information through the organizations listed below.
<input type="checkbox"/> Share my information through the organizations listed below with all my past, current, and future treating providers. If I choose this option, I can request a list of providers who have seen my records.

Section 3: Select if all information can be shared or if only specific information can be shared.

Section 3: What Information You Want to Share
 Choose one option:

Share **all** my 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 I am being treated for, my medications, lab results, etc.

1. _____ 4. _____
 2. _____ 5. _____
 3. _____ 6. _____

Section 4: This section outlines how the information that is shared will be used. A ROI is valid for one year from the signed date, unless the individual fills in the highlighted area with a specific date, event, or condition. If the individual does not wish to add a specific date or event, it can be left blank.

Section 4: Your Consent and Signature
 Read the statements below, then sign and date the form.

By signing this form below, I understand:

- I am giving consent to share my 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.
- I do not have to fill out this form. If I do not fill it out, I can still get treatment, health insurance or benefits. But, without this form, my provider or health plan may not have all the information needed to treat me.
- My records listed above in Section 3 will be shared to help diagnose, treat, manage, and pay for my health needs.

Signature Section: Once all sections have been completed, the individual, parent (if person is a minor), or Guardian selects their relationship to person giving consent and then signs/dates.

State your relationship to the person giving consent and then sign and date below:

Self _____

Parent (Print Name) _____

Guardian (Print Name) _____

Authorized Representative (Print Name) _____

Signature	Date
Witness Signature (If Appropriate)	Date

Section 5: If the individual previously had given consent for information to be shared and they wish to withdraw that consent, this section would be signed.

Section 5: Who Can No Longer See Your Information

I no longer want to share my records with those listed in Sections 2a and 2b. I understand any information already shared because of past approval cannot be taken back.

State your relationship to the person withdrawing consent, then sign and date below.

- Self _____
- Parent (Print Name) _____
- Guardian (Print Name) _____
- Authorized Representative (Print Name) _____

Signature	Date
Witness Signature (If Appropriate)	Date