AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Michigan Department of Health and Human Services

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

TO:

SECTION 1:
I authorize you to release the named adult and/or minor child's information as described below. Under no circumstances can this release be used to disclose confidential children protective services information or records. The type and amount of information to be released is as follows:

REQUESTED INFORMATION

☐ **MEDICAL RECORDS OF:** _____

Physical examinations and clinical evaluations including any information relative to HIV, ARC or AIDS if applicable. Treatment for any physical illness. Medical records, including admitting histories, discharge summaries, laboratory reports, test results, diagnosis, complications, progress notes, medications, workshop evaluations, training reports, treatment plans, prognosis, recommendations and current status.

☐ **MENTAL HEALTH RECORDS OF:** _____

Treatment for any emotional illness, psychiatric or psychological reports, IQ scores, diagnosis, progress notes, medications, treatment plans, prognosis, recommendations and current status.

☐ **SUBSTANCE/ALCOHOL ABUSE RECORDS OF:** _____

Treatment for any drug or alcohol abuse, laboratory reports, test results, diagnosis, complications, progress notes, medications, treatment plans, prognosis, and current status.

☐ **EDUCATIONAL RECORDS OF:** _____

School records including progress reports, attendance, special education and other evaluations, IEP, unofficial transcript, discipline records, behavior intervention plans, 504 plan, test data, standardized scores and any psychological records.

☐ OTHER (Specify) OF: _____

☐ OTHER (Specify) OF: _____

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 released during the course of business to organizations that regularly review child welfare cases including Office of Children's Ombudsman, Foster Care Review Board, Citizen's Review Panel, Friend of the Court, County Medical Examiner, law enforcement, and Child Fatality Review Team.

SECTION 2:
This information may be released to and used by the following:

☐ _____ County Michigan Department of Health and Human Services

_____
Address (Street)

_____
Address (City, State, Zip Code)

_____ _____
Phone Number Fax Number

☐ _____ County Family Division of Circuit Court

☐ _____ County Prosecuting Attorney

☐ Attorney Representing Mother

☐ Attorney Representing Father

☐ Lawyer – Guardian Ad Litem Representing Child(ren)

☐ Service Provider (specify) _____

☐ Service Provider (specify) _____

☐ Service Provider (specify) _____

☐ Court Appointed Special Advocate (CASA)

☐ Law Enforcement

☐ Other (specify) _____

☐ Other (specify) _____

SECTION 3:
This release and use is for the following purpose(s): To assist the Michigan Department of Health and Human Services in conducting child and family assessments for the purpose of providing case planning and treatment services. Information regarding the youth's care, supervision and treatment may be released to law enforcement by any party listed on this form when law enforcement is responding to a call involving the child and/or his family that could impact the court-ordered case service plan.

☐ 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.)

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

Unless otherwise revoked, this authorization will expire on the following date, event or condition. (If I fail to specify an expiration date, event or condition, this authorization will expire one year from the signature date):

☐ Court jurisdiction dismissed

☐ Children's services case closed

☐ Other (specify) _____

I understand that release of this 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 release of information carries with it the potential for an unauthorized release 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)	**Printed Name of Witness (Worker)**
Signature of Client (or Legal Representative) Date	**Signature of Witness (Worker)** Date
If signed by Legal Representative, Relationship to Client: **(A letter of authority may be requested)**	

MDHHS 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
- 1978 PA 368
- 1978 PA 238
- 1974 PA 258

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