HURON COUNTY Health Department

FAX RECORDS TO (989) 269-4181

AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION FOR CARE COORDINATION

Children's Special Health Care Services

Completion of this form authorizes 2-way communication between the Huron County Health Department (HCHD) and an outside provider, organization or facility to share my information so care coordination services can be provided.

ALL 5 SECTIONS MUST BE COMPLETED FOR AUTHORIZATION TO BE VALID. INCOMPLETE FORMS WILL NOT BE HONORED.

SECTION 1: PATIENT INFORMATION

Patient Name (First, Middle Initial, Last Name)	Date of Birth
Patient Address	CSHCS/Medicaid ID Number
City State Zip Code	County
Parent/Guardian Name	Parent/Guardian Phone Number
Parent/Guardian Address (If different than patient)	City State Zip Code

SECTION 2: NAME OF OUTSIDE PROVIDER, ORGANIZATION OR FACILITY

Name of outside provider, organization or facility			
Address	City	State	Zip Code
Phone Number	Fax Number		

SECTION 3: INFORMATION TO DISCLOSE/RELEASE & PURPOSE FOR DICLOSING/SHARING INFORMATION

Date of Information Requested: ***Most recent medical records from the past 12 months***	Reason ***Coordination of Care***

SECTION 4: WHO SHOULD RECEIVE THE INFORMATION REQUESTED

Provider/Facility **Huron County Health Department / Children's Special Healthcare Services (CSHCS)**			
Address **1142 S. Van Dyke Rd.**	City **Bad Axe**	State **Michigan**	Zip Code **48413**
Phone Number **989-269-3330**	Fax Number **989-269-4181**		

SECTION 5: SIGNATURE & AUTHORIZATION EXPIRATION DATE

- The organization listed in Section 2 may disclose my protected health information (PHI) for my care coordination.
- Unless revoked, this authorization expires 12 months from the date signed.
- I have the right to end (i.e. revoke) this authorization by notifying the health department program (that is sharing the information to coordinate my services) of my request in writing.
- If I make a request to end this authorization, it will not include information that has already been disclosed based on my previous permission.
- My refusal to sign this authorization will not affect my ability to obtain treatment, payment for services, enrollment or eligibility for benefits.
- I may request a copy of this signed authorization.
- If I choose not to agree with this request, my benefits or services will not be affected.
- I understand that this information is protected by Federal and state laws and cannot be disclosed without my consent unless otherwise provided in the regulations
- These records may include any information about behavioral and mental health services, substance use disorder treatments, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC); any other communicable diseases as defined by MDHHS.

Signature of Patient or Legal Guardian	Print Name of Patient or Legal Guardian	Date Signed