



DCH-3927: BEHAVIORAL HEALTH STANDARD CONSENT FORM BACKGROUND INFORMATION

Health information sharing is an important part of delivering quality health care to individuals. Individuals and their health care providers share information with each other to diagnose health issues, make decisions about treatments, and coordinate care.

Health care providers may share many kinds of health information with other providers for the purposes of payment, treatment, and health care operations. However, providers must receive specific consent to share an individual's health records containing certain types of information. In Michigan, federal and state laws require providers to receive consent to share the following types of information:

- Behavioral health or mental health services that are provided by the Michigan Department of Community Health (MDCH), a Community Mental Health Service Provider, or an entity under contract with the MDCH or a Community Mental Health Service Provider
- Referrals and /or treatment for a substance use disorder
- Communicable diseases such as sexually transmitted diseases and human immunodeficiency virus (HIV Infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex)

In the past, providers in Michigan have developed his or her own form to receive the individual's consent to share the above types of information. The differences between forms made sharing information across the health care system difficult for individuals and providers.

To address this problem, the Michigan legislature passed a law (Public Act 129 of 2014), which directed MDCH to create a standard consent form for sharing the types of information listed above. The goal of the law is to make the consent process simpler for individuals and providers in Michigan.

MDCH recognizes that multiple laws, statutes, and regulations govern the sharing of health information. The Department designed the consent form to align with the requirements contained in the Health Insurance Portability and Accountability Act (HIPAA), 42 Code of Federal Regulations Part 2, the Michigan Mental Health Code, and the Michigan Public Health Code.

Public Act 129 requires "all public and private agencies, departments, corporations, or individuals that are involved with treatment of an individual experiencing serious mental illness, serious emotional disturbance, developmental disability, or substance use disorder" to accept and honor the standard form (DCH-3927) unless the entity is held to more stringent requirements under federal law. The following entities are held to more stringent requirements and are not required to accept DCH-3927:

Individuals and agencies that provide services under the Violence Against Women Act or Family Violence Prevention and Services Act. These individuals and agencies should not use the standard form and must complete a separate release for sharing health information. These entities can refer to the "[Provider Specific Frequently Asked Questions](#)" document or www.michigan.gov/domesticviolence for more information.

For additional information about DCH-3927, contact the Department by phone at 844-275-6324 or by email at MDCH-BHConsent@michigan.gov.

This document is for informational purposes only.

It is not intended to provide legal advice or to address all circumstances that might arise. Individuals and entities using this document are encouraged to consult their own legal counsel.

THINGS TO CONSIDER WHEN GIVING CONSENT TO SHARE HEALTH INFORMATION

YOUR INFORMATION. YOUR RIGHTS. YOUR CHOICES.

YOUR INFORMATION

When you receive health care, your health care provider keeps records about your health and the services you receive:

- These records (which include any information about the services, tests, diagnoses, treatment, etc. that you receive) become a part of your medical record.
- Under the Health Insurance Portability and Accountability Act (HIPAA), your health care provider does not need your consent to share most types of your health information for purposes of payment, treatment, and health care operations.
- Other federal and state laws require your health care provider to get your consent to share certain types of health information such as:
 - Behavioral health and mental health services¹
 - Referrals and /or treatment for a substance use disorder²
 - Communicable diseases such as sexually transmitted diseases and human immunodeficiency virus (HIV Infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex)³

YOUR RIGHTS AND CHOICES

Concerning the types of information described above, you have the right to:

- Talk with your provider about the benefits and risks of sharing your health information
- Choose whether to sign the form and provide your consent
- Choose what information is shared
- Choose who should receive your health information
- Choose the time period for sharing your information (for example, one month, six months, one year, etc.)
- Withdraw your consent to share your information
- Receive a copy of your medical records
- File a complaint if you believe information has been shared against your wishes

¹ P.A. 258 of 1974 and MCL 330.1748

² 42 CFR Part 2

³ P.A 368 of 1978, MCL 333.1101 et seq. Under the Michigan Public Health Code, information may be shared without consent for prevention, care and treatment of communicable diseases.

Michigan Department
of Community Health



Rick Snyder, Governor
Nick Lyon, Director

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MICHIGAN DEPARTMENT OF COMMUNITY HEALTH CONSENT TO SHARE YOUR HEALTH INFORMATION

THIS FORM CANNOT BE USED FOR A RELEASE OF INFORMATION FROM ANY PERSON OR AGENCY THAT HAS PROVIDED SERVICES FOR DOMESTIC VIOLENCE, SEXUAL ASSAULT OR STALKING. A SEPARATE CONSENT MUST BE COMPLETED WITH THE PERSON OR AGENCY THAT PROVIDED THOSE SERVICES. (See FAQ at www.michigan.gov/bhconsent to determine if this restriction applies to you or your agency)

Individual's Name: _____ **Date of Birth:** _____

Individual's ID Number (Medicaid ID, SSN, other): _____

Your consent is needed to share certain types of your health information including:

- Behavioral and mental health services
- Referrals and treatment for alcohol and substance use disorder
- Communicable diseases such as sexually transmitted diseases and human immunodeficiency virus (HIV Infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex)

This information will be shared to help diagnose, treat, manage and get payment for your health needs. You can consent to share all of this information or just some information. (See FAQ at www.michigan.gov/bhconsent)

I. I consent to share my information among:

(Additional persons or agencies can be added at top of the next page)

1. _____ 3. _____
2. _____ 4. _____

II. I consent to share:

- All of my health information listed above
-OR-
 All of my information listed above except:
(list types of health information you do not want to share)

III. By signing this form I understand:

- My information may be shared among each agency and person listed above
- My information will be shared to help diagnose, treat, manage and pay for my health needs
- My consent is voluntary and will not affect my ability to obtain mental health or medical treatment, payment for medical treatment, health insurance or benefits
- My health information may be shared electronically
- This form does not affect the sharing of my physical health information for purposes of treatment, payment, or health care operations or as otherwise allowed by law
- The sharing of my health information will follow state and federal laws and regulations
- This form does not give my consent to share psychotherapy notes as defined by federal law
- I can withdraw my consent at any time; however any information shared with or in reliance upon my consent cannot be taken back
- I should tell all agencies and people listed on this form when I withdraw my consent
- I can have a copy of this form

My consent will expire on the following date, event or condition unless I withdraw my consent.
(If expiration date is left blank or is longer than one year, the consent will expire 1 year from the signature date)

I have read this form or have had it read to me in a language I can understand. I have had my questions about this form answered.

Signature of person giving consent or legal representative

Date

Relationship to Individual

- Self Parent Guardian Authorized Representative

Additional persons or agencies – continued from previous page

5. _____ 8. _____
6. _____ 9. _____
7. _____ 10. _____

WITHDRAW OF CONSENT

I understand that any information already shared with or in reliance upon my consent cannot be taken back.

I withdraw my consent to the sharing of my health information:

- Between any of the following persons or agencies:

-OR-

- For all persons and agencies

Signature of person withdrawing consent or legal representative

Date

Relationship to Individual

- Self Parent Guardian Authorized Representative

Verbal Withdraw of Consent:

This consent was verbally withdrawn.

Signature of person receiving verbal withdraw of consent

Date

- Individual provided copy Individual declined copy

AUTHORITY: This form is acceptable to the Michigan Department of Community Health as compliant with HIPAA privacy regulations, 45CFR Parts 160 and 164 as modified August 14, 2002, 42 CFR Part 2, PA 258 of 1974 and MCL 330.1748 and PA 368 of 1978, MCL 333.1101 et seq and PA 129 of 2014, MCL 330.1141a.

COMPLETION: Is Voluntary, but required if disclosure is requested.

The Michigan Department of Community Health is an equal opportunity employer, services, and programs provider.