Behavioral Health Coordination of Care Consent

FOREST HILLS PEDIATRIC ASSOCIATES, PC
877 Forest Hill Ave SE
Grand Rapids, MI 49546
616-949-4465
Fax: 616-949-6191

Patient First Name	Middle Initial	Patient Last Name	Date of Birth

I consent to share my information between **Forest Hills Pediatrics** and:

Mental health professional: _____

Mental health facility and Phone Number: _____

- ❑ **I do NOT see a mental health provider outside of Forest Hills Pediatrics.**

I consent to share (choose one):

- ❑ All of my mental health, behavioral health and substance use disorder information
- ❑ All of my mental health, behavioral health and substance use disorder information except:

_____

By signing this form, I understand:

I am giving consent to share my behavioral health and substance use disorder information. Behavioral health and substance use disorder information includes, but is not limited to, referrals and services for alcohol and substance use disorders.

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 (please circle one): **Self** **Parent** **Guardian**

I understand I can withdrawal my consent at any time, otherwise, if I do not specify a date, my consent will expire 1 year from the signature date.
Expiration Date (leave blank if consent for 1 year): _____

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Under the Health Insurance Portability and Accountability Act (HIPAA), a health care provider or agency can use and share most of your health information in order to provide you with treatment, receive payment for your care, and manage and coordinate your care. However, your consent is needed to share certain types of health information. This form allows you to provide consent to share the following types of information.

- Behavioral and mental health services
- Referrals and treatment for an alcohol or substance abuse disorder

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)

By signing this form, I understand:

- I am giving consent to share my behavioral health and substance use disorder information. Behavioral health and substance use disorder information includes, but is not limited to, referrals and services for alcohol and substance use disorders.
- 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.
- Other types of my information may be shared with my behavioral health and substance use disorder information. HIPAA allows my providers and other agencies to use and share most of my health information without my consent in order to provide me with treatment, receive payment for my care, and to manage and coordinate my care.
- 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.

Expiration Date (leave blank if consent for 1 year): _____