AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Directions: Type or Print all requested information, with exception of signatures on Page 2.

Individual's Name (Beneficiary, Recipient, Patient, Consumer, etc.)			**Individual's ID Number** (Medicaid, SSN, Other)
Street Address			**Individual's Date of Birth**
City	**State**	**ZIP**	**Phone**

I authorize the Michigan Department of Health and Human Services (MDHHS) to disclose the above-named individual's health information as described below. (Identify type and amount of information, including dates where appropriate.)

Any and all records as kept in your system regarding myself.

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 and/or treatment for alcohol and drug abuse (as permitted by MCL 330.1748, P.A. 258 of 1974 and 42 CFR Part 2).

This information may be disclosed to and used by the following person or organization:

	CD SERVICES, INC
(Person/Individual's Name)	(Organization Name)

Name of Person/Organization authorized to receive the protected health information.

24027 RESEARCH DRIVE

Street Address

FARMINGTON HILLS, MI 48335

City, State, ZIP

248-476-1700	248-476-6600
Phone Number	Fax Number

This disclosure and use is for the following purpose(s):* See Note below.

For any and all purpose(s) permitted or required by law, at my request.

(* 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 permission, I have the right to change my mind and **revoke** it. This must be in writing to the Facility or MDHHS Program that maintains the individual's records that I authorized on Page 1 of this form. I also understand that any uses or disclosures already made with my permission cannot be taken back.

If this authorization is needed as a condition to obtain health care coverage and I revoke it, then I understand that the above person/organization who would have received the information may have the right to contest health care coverage claims.

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.)

_____

Date, Event or Condition

I understand that authorizing the disclosure of this health 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, payment for services, or eligibility for benefits unless the information is necessary to demonstrate that I meet eligibility or enrollment criteria.

By signing this Authorization, I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules. I further understand I may request a copy of this signed Authorization.

Legal Representative's Name (If applicable)	**Legal Representative's Relationship to Individual** (A letter of authority may be requested.)
Signature of Individual or Legal Representative	**Date**
Signature of Witness	**Date**

MDHHS Use Only

This authorization was revoked:

_____

Signature **Date**

AUTHORITY: This form is acceptable to the Michigan Department of Health and Human Services as compliant with HIPAA privacy regulations, 45CFR Parts 160 and 164 as modified August 14, 2002.

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