Oakland County Government
Interagency Consent and Authorization
To Release Protected Health Information

1. **I grant permission to** (check one or more):

☐ Circuit Court-Family Division	☐ DHHS/Children's Village	☐ Medical Examiner
☐ Community Corrections	☒ DHHS/Health Division	☐ Employment & Training
☐ Community Mental Health		☐ Mich. Dept. of Human Services-Oakland
☐ Sheriff's Department	☒ Other (specify) **Children's Special Health Care Services**	

To release information on:
Name of Person: _____ DOB or SS#: _____

2. **This information may be released to the following** (check one or more):

☐ Circuit Court-Family Division	☐ DHHS/Children's Village	☐ Medical Examiner
☐ Community Corrections	☐ DHHS/Health Division	☐ Employment & Training
☐ Community Mental Health		☐ Mich. Dept. of Human Services-Oakland
☐ Sheriff's Department	☒ Other (specify) Any organization or individual (i.e., a parent) assisting with the provision and/or coordination of services.	

Name: _____

3. **What information may be released:** Information needed to provide/coordinate services
☐ I give permission to receive information via text messages.
Signature: _____ Cell Phone**:** _____

4. **For what purpose is the information to be released**:

☒ To assist in the coordination and/or provision of services
☐ Other (specify)_____

5. **I understand that I have a right to receive a copy of this document.**

6. **I understand that I may withdraw this consent** by written notification received by the agency head at any time before information is released. I also understand that disclosure of the above protected health information may be subject to redisclosure by the recipient and, therefore, may no longer be protected. I further understand that redisclosure of substance abuse-related information by the recipient is prohibited unless authorized by 42 CFR, Part 2.

7. **Unless withdrawn in writing, this consent expires as follows**:

A. Date: When client is no longer enrolled in Children's Special Health Care Services
B. Event:_____
C. Condition:_____

***NOTE: AIDS-related information (i.e., HIV, ARC, AIDS) and/or psychotherapy notes shall not be released unless specifically listed under Item #3 above**.

X_____ **X**_____
Client/Parent/Guardian Signature (Relationship) Date

X_____ **X**_____
Witness Signature Date

☐ **HIPAA Acknowledgement:** I have received a copy of Oakland County's Notice of Privacy Practices.

X_____ **X**_____
Signature Date

This authorization is consistent with standards established under 42 CFR, Part 2; 45 CFR, Parts 160 and 164; and Michigan Law. No Oakland County agency may release protected health information without a current valid written authorization in its possession or as otherwise provided by law.