MATERNAL CONSENT TO RELEASE PROTECTED HEALTH INFORMATION

Upper Peninsula (UP) Maternal Opioid Misuse (MOM) Model Program

We would like to be able to share and exchange your health information with your doctors and other agencies so that we can give you and your infant the best possible care.

I authorize and request the parties listed below to share and exchange all of my health information with each other:

Name of Prenatal Care Provider:	Date:	Initialed by Beneficiary
Name of Other Parties with Whom Information may be Exchanged	**Date:**	**Initialed by Beneficiary**
Marquette County Health Department		
Women, Infant, Children (WIC)		
Upper Peninsula Health Plan (UPHP)		
Marquette Department of Health and Human Services (MDHHS)		
Upper Peninsula Health Care Solutions (UPHCS)		
Maternal Infant Health Program (MIHP)		
Great Lakes Recovery Center (GLRC)		
Obstetrics (OB) / Neonatal Intensive Care Unit (OB UNIT / NICU)		
Upper Great Lakes Family Health Center (UGLFHC)		
Pathways		
NorthCare Network		

1. I understand that this may include information about behavioral and/or mental health services, sexually transmitted diseases, human immunodeficiency virus and other communicable diseases, and referral and/or treatment for substance abuse.
2. I understand that:
   a. Consenting to the exchange of this health information is voluntary.
   b. I may refuse to sign this consent.
   c. My refusal to sign will not affect my Medicaid eligibility or benefits.
3. I understand that if I give consent:
   a. I have the right to change my mind and cancel at any time. Any information already released cannot be taken back.

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b. I must give written notice to my MOM Community Health Worker if I decide to cancel my consent.

4. I understand that disclosure of certain information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal privacy rules. Substance abuse patient records can only be re-disclosed to agencies listed in this form.

5. I understand that I may request a copy of this signed consent.

6. I understand that this consent will expire at the end of MOM services unless I cancel it before expiration of services.

7. The purpose of this consent is to improve the MOM services provided to me.

I have read the above or it has been read and explained to me.

I understand that I may receive MOM services without consenting to release my protected health information.

☐ I DO consent to the release of protected health information as specified in this form.

☐ I DO NOT consent to the release of protected health information as specified in this form.

Beneficiary Name (Print)	Legal Representative Name if applicable (Print)	Legal Representative Relationship to Beneficiary
Signature of Beneficiary or Legal Representative		Date
Signature of MOM program worker		Date