LifeWays
Community Mental Health

Authorization to Exchange Information between LifeWays CMH and MDHHS (Michigan Department of Health and Human Services)

Instructions on completing this Health Insurance Portability and Accountability Act of 1996 (HIPAA) form:

1. All areas should be complete
2. This form must be signed and dated by the patient or guardian.
3. This form can be faxed to 517-796-4532 or returned to the LifeWays Network Benefits Team

Patient First Name:	Patient Last Name:	Date of Birth:

Patient Address (street, city, zip):

Guardian Name: Check if Not Applicable ☐

This authorization will be valid for a period of ONE YEAR From the signed date, unless a lesser time frame is indicated: Alternative Expiration Date:	Authorized provider, LifeWays Community Mental Health, 1200 N. West Ave, Jackson, MI 49202 to exchange the information identified below to and from: Michigan Department of Health and Human Services

I, or my guardian, request that information regarding federal/state program benefit determination and contact information including- but not limited to- first name, last name, phone number, and address be exchanged to LifeWays Community Mental Health for purpose of any state/federal benefits (cash, food, Medical).

I understand that:

1. Protected health information may include information and records protected under federal and state law such as benefit determination and first name, last name, phone number, and address.
2. My treatment, payment or eligibility of benefits may not be conditioned on signing this authorization.
3. I understand that I may revoke this authorization at any time by writing to LifeWays, Attn: Customer Services, 1200 N. West Ave. Jackson, MI 49202, except to the extent that LifeWays has taken action in reliance to the authorization.
4. It is recommended I retain a copy of this signed form for my records, understanding that a copy is as valid as the original.

_____ _____

Signature of Claimant/Consumer, Guardian or Authorized Representative — Date

_____ _____

Printed Name of Claimant/Consumer, Guardian or Authorized Representative — Date