AUTHORIZATION TO DISCLOSE BLOOD LEAD TEST RESULT DATA:

Michigan Department of Health and Human Services

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

Individual's Name (Beneficiary, Recipient, Patient, Consumer, etc.)			Individual's Gender
Street Address			Individual's Date of Birth / /
City	State	ZIP Code	Phone ( ) -

I AUTHORIZE THE MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES (MDHHS) TO SHARE MY HEALTH INFORMATION:

ALL BLOOD LEAD TEST RESULTS ON RECORD AFTER APRIL 1, 2014

MDHHS MAY SHARE MY HEALTH INFORMATION WITH THE FOLLOWING PERSON OR ORGANIZATION:

Name of Person/Organization

Street Address

City, State, ZIP Code

( ) - ( ) -

Phone Number Fax Number

MDHHS WILL SHARE MY BLOOD LEAD TEST RESULTS FOR THE FOLLOWING REASON:

Blood lead test results will be shared with the Claim Administrator to provide proof of blood lead tests for the purpose of making a claim for compensation in the Flint Water Settlement.

BY SIGNING THIS FORM, I UNDERSTAND THAT:

- I do not have to sign this authorization.
- MDHHS Childhood Lead Poisoning Prevention Program will search the blood lead tables based off Name, Date of Birth and Gender provided with this release. The blood lead data tables contain the test result and patient information as reported by the testing facility, unless updated based off of additional resources.
- Other types of information shared under this authorization may be re-disclosed by the person or organization I identified above and may no longer be protected by federal or state law.
- I may change my mind and revoke (take back) this authorization at any time. To revoke this authorization, write to the MDHHS program that maintains your records and include a copy of the front of this form.
- Information that has already been shared based on this authorization cannot be taken back.
- I may request a copy of this signed authorization. If I have not previously revoked this authorization, it will expire on: *(list a date, event or condition)*

Date, Event or Condition
(Authorization will expire one year from the signature date if you leave this section blank.)

Signature of Individual or Legal Representative	Date / /
Name of Individual or Legal Representative	
Legal Representative's Relationship to Individual (i.e., Parent, Guardian, Patient Advocate, Authorized Representative, Power of Attorney. Documentation may be required.)	

MDHHS USE ONLY

This authorization was revoked:

/ /

Signature Date

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

Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs, or disability.