MDHHS

Michigan Department of Health and Human Services AUTHORIZATION FOR RELEASE OF INFORMATION

I, Bridget Spivey authorize the Department of Health & Human Services (DHHS) to release otherwise confidential information to Senator/Representative Bolden, or his or her designee, related to my case record, unless otherwise restricted by state or federal law. The case record information for which I am providing this authorization includes:

Please provide a brief description of the issue.

I need some assistance with food and transportation. Also, I'm in need of adult services.

DHS Programs needing information on (please check those that apply):

___ Food Assistance	_X_ Cash Assistance	___ Medicaid
___ State Emergency Relief	___ State Disability	___ Child Day Care
_X_ Adult Services	___ Other	

Constituent Information:

Name Bridget Spivey **Case #** 102896973

Address 5000 Town Center, APT. 1601 **City/Zip** Southfield, Mich. 48075

Phone Number 248-799-0911

X Constituent Signature Bridget Spivey Date: _____

Please note - the Department is not able to share case-specific information on Children's Protective Services, Foster Care, Adoption or Child Support.

MDHHS

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

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 ID Number (Medicaid, SSN, Other)
Bridget R. Spivey			19269494
Street Address			**Individual's Date of Birth**
5000 Town Center, Apartment 1601			12/05/1954
City	**State**	**ZIP Code**	**Phone**
Southfield	MI	48075	(248) 799-0911

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

List the amount or type of information you would like to share in the section below.
For example, you can say all my health information or list certain types of information you would like to share.

Eligibility for services, services rendered, medical conditions, and claims.

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

Representative Kyra Bolden
Name of Person/Organization

PO BOX 30014
Street Address

Lansing mi 48909
City, State, ZIP Code

5173731788 ( ) -
Phone Number Fax Number

MDHHS WILL SHARE MY HEALTH INFORMATION FOR THE FOLLOWING REASON:

For example, to discuss my health care benefits or at the request of the individual.

At the request of the individual.

BY SIGNING THIS FORM, I UNDERSTAND THAT:

- I do not have to sign this authorization.
- My refusal to sign this authorization will not affect my ability to obtain treatment, payment for services, enrollment or eligibility for benefits.
- **Information regarding behavioral and mental health services, substance use disorder treatments, and communicable diseases such as sexually transmitted diseases and human immunodeficiency virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS related complex) may be shared if I initial here or if I list this type of information above _____.**
- If I authorize the release of substance use disorder treatment information, the recipient cannot re-disclose this information without my permission unless permitted under federal or state law.
- 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
Bridget Spivey	09/16/2019
Name of Individual or Legal Representative: Bridget Spivey	
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:

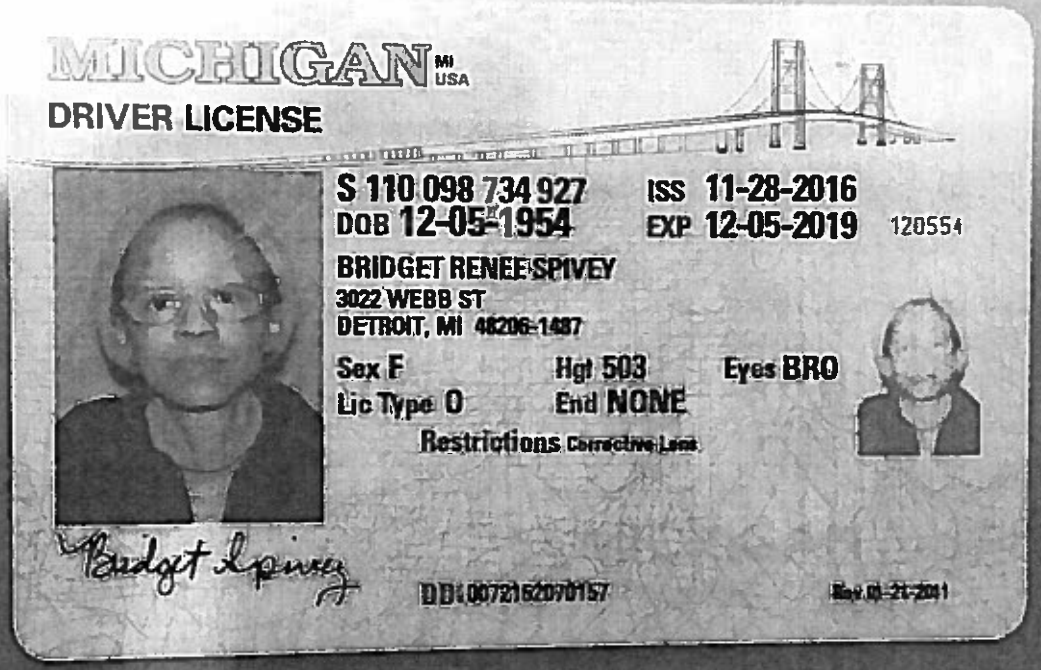
/ /

Signature Date

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.

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.


MICHIGAN MI USA
DRIVER LICENSE
S 110 098 734 927
DOB 12-05-1954
ISS 11-28-2016
EXP 12-05-2019
120554
BRIDGET RENEE SPIVEY
3022 WEBB ST
DETROIT, MI 48206-1487
Sex F
Hgt 503
Eyes BRO
Lic Type O
End NONE
Restrictions Corrective Lens
DD 00721620701S7