

MDHHS 5515 – Consent to Share Behavioral Health Information Training

July 2026



Housekeeping

- The slides and recording will be shared after the webinar
- We encourage you to put questions in the chat throughout the presentation
- For questions we do not have time to answer, answers will be shared broadly in a follow-up memo
- Please stay muted when not asking a question
- Please be aware of your language and try to use affirming and non-pejorative language

Disclaimer: Nothing presented today should be construed as legal advice. Please consult your legal counsel for more information.

Today's Agenda

Fundamentals of Consent

Consent Laws and Regulations

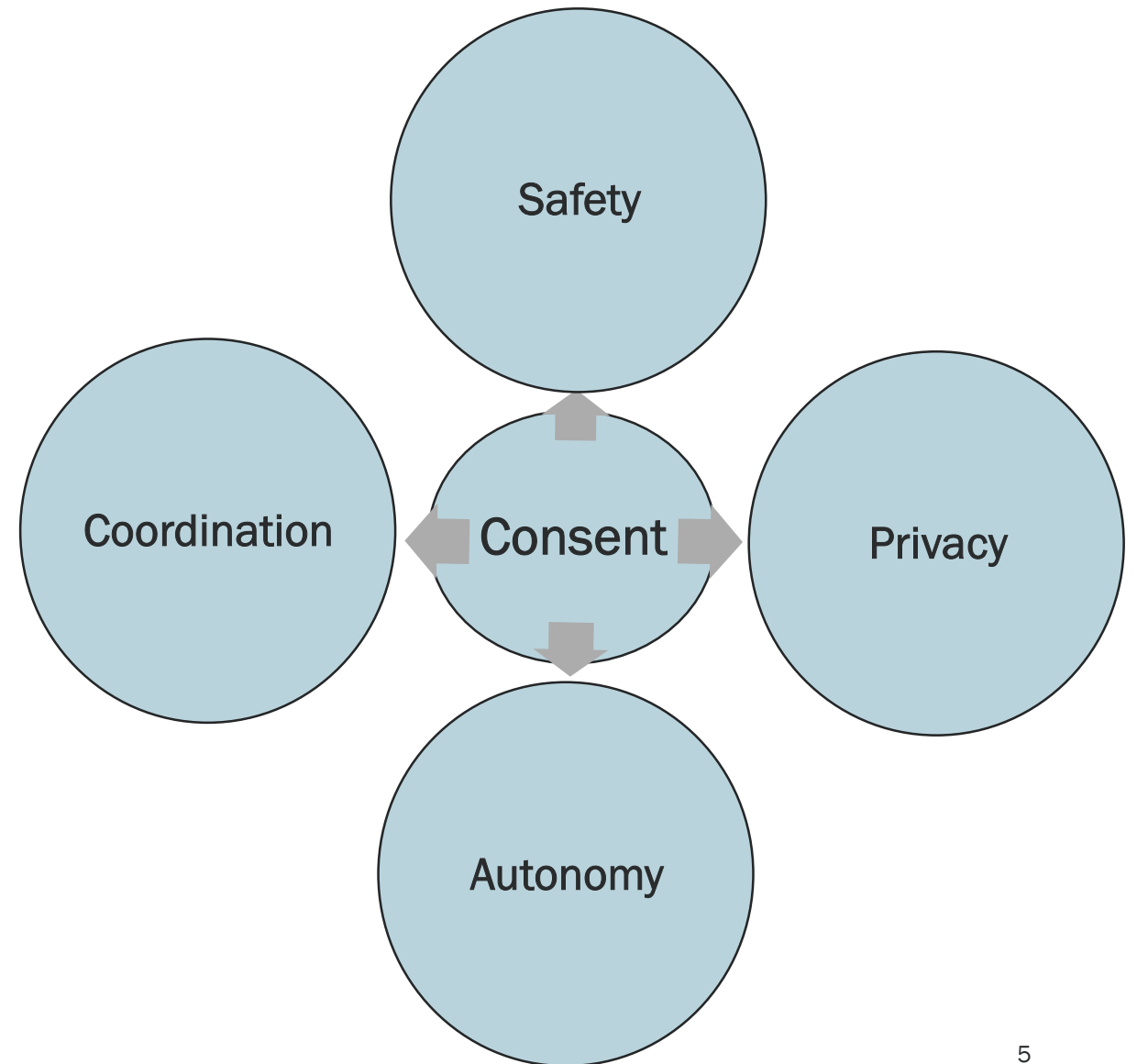
5515 (v 9-25) Overview

Form Scenarios

Poll

Fundamentals of Consent

- Informed consent is an ongoing process
- All four components are important to consider: will this impact the safety of someone, is it necessary for coordination, does it protect autonomy and privacy?
- Consent can be changed or revoked at any time
- This presentation focuses on the consent to share information (not for treatment)



Laws and Regulations

HIPAA

- Federal regulation governing sharing of health information between providers/payors
- Allows for sharing without patient consent for Treatment, Payment, and Operations (TPO) purposes
- Minimum necessary standard
- No special protection for behavioral health or substance use disorder information

Michigan Mental Health Code

- Established need for consent to share behavioral health information
- Updated in 2016 to allow for no consent required TPO sharing for mental health
- Includes separate pathway for court-ordered release of information in alignment with Part 2

42 CFR Part 2

- Federal regulations protecting SUD information sharing for “Part 2” programs
- **2024 Update**
 - Closer alignment with HIPAA
 - Allows for one-time consent for all TPO future uses
 - Lessens restrictions on data segmentation requirements
 - Records released via TPO cannot be used against a person in criminal or civil proceedings
 - Requires redisclosure statement

5515 Consent to Share Behavioral Health Information

Public Act 129 requires “all public and private agencies, departments, corporations, or individuals that are involved with treatment of an individual experiencing serious mental illness, serious emotional disturbance, developmental disability, or substance use disorder” to accept and honor the standard form (MDHHS-5515) unless the entity is held to more stringent requirements under federal law.*

- Created as a means to help providers be in alignment with state and federal law
- Standardized method for clients to give or take away consent to share information related to mental or behavioral health
- Can be a required component for program participation
- Can be added to EHR if content is maintained

* Individuals and agencies that provide services under the Victims of Crime Act, Violence Against Women Act, or Family Violence Prevention and Services Act should not use the standard form.

MDHHS-5515 (Rev. 9-25) Changes

- **Form now includes TPO-based consent sharing (section 2) for SUD information**
 - TPO – Treatment, Payment, and Healthcare Operations
- **Why this is important:**
 - Only requires one consent for routine care coordination and billing (for medical providers and payors only)
 - Reduces need for multiple consent forms
 - Does not expire unless specified

MDHHS-5515, CONSENT TO SHARE BEHAVIORAL HEALTH INFORMATION
Michigan Department of Health and Human Services (MDHHS)
(Revised 9-25)

Use this form to give or take away your consent to share information about your:

- Mental and behavioral health services. This will be referred to as "behavioral health" throughout this form.
- Diagnosis, referral, and treatment for an alcohol or substance use disorder. This will be referred to as "substance use disorder" throughout this form.

This information will be shared to help diagnose, treat, manage, and pay for your health needs.

If using this form for multiple party disclosures, all information identified will be shared with all parties identified on this form. If this is not the goal, use separate forms.

Why This Form Is Needed

When you receive health care, your health care provider and health plan keep records about your health and the services you receive. This information becomes a part of your medical record. Under state and federal laws, your health care provider and health plan do not need your consent to share most types of your health information to treat you, coordinate your care, or get paid for your care. But they may need your consent to share your behavioral health or substance use disorder records.

Instructions

To give consent, fill out Sections 1, and then fill out either section 2 Treatment, Payment, and Healthcare Operations (TPO) only, sections 3 and 4 only or sections 2, 3 and 4.

This consent will not be used for any civil, criminal, administrative, or legislative proceedings.

To take away consent, fill out Section 6.

Sign the completed form, then give it your health care provider. They can make a copy for you.

SECTION 1 - ABOUT YOU

Name (First, Middle Initial and Last)

Date of Birth

SECTION 2 - TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS (TPO)

Sharing information between individuals and organizations

Consent for All Future Uses for Treatment, Payment, and Health Care Operations

- ☐ Share all behavioral health and substance use disorder information with all my treating providers, health plans, third-party payers, and people helping to operate this program for treatment, payment, and health care operations.

Expiration for TPO consent: Unless otherwise specified below, this consent does not expire.

- ☐ This consent expires (optional) _____

When providing a consent for treatment, payment, and health care operations there is the potential for the records used or disclosed pursuant to the consent to be subject to redisclosure by the recipient and no longer protected by 42 CFR Part 2.

If you do not consent to sharing for treatment, payment, and health care operations the consequences, if any, are _____

SECTION 3 - WHO CAN SEE YOUR INFORMATION AND HOW THEY CAN SHARE IT

A. Let us know who can see and share your behavioral health and substance use disorder records. You should list the specific names of health care providers, health plans, family members, or others. They can only share your records with people or organizations listed below.

☐ Health Plan - _____ ☐ Pre-paid Inpatient Health Plan (PIHP) - _____

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

B. Sharing Information Electronically

Health information exchanges or networks share records back and forth electronically. This type of sharing helps the people involved in your health care. It helps them provide better, faster, safer, and more complete care for you. Your health care provider and health plan may have already listed these organizations below.

Choose only one option:

- ☐ Share my information through the organizations listed below. This information will be shared (not shared) with the individuals and organizations listed under Section 3a.
- ☐ Do not share my information through the organizations listed below.
- ☐ Share my information through the organizations listed below with all of my past, current, and future treating providers. If I choose this option, I can request a list of providers who have seen my records.

For Health Care Provider or Health Plan Use Only.

List all health information exchanges or networks:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

SECTION 4 - WHAT INFORMATION YOU WANT TO SHARE

Choose one option:

- ☐ Share all my behavioral health and substance use disorder records. This does not include "psychotherapy notes and/or substance use disorder counseling notes."
- ☐ Share only the types of behavioral health and/or substance use disorder records listed above. For example, what I am being treated for, my medications, lab results, etc.

Types of Records

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

The expiration date, event, or condition for Sections 3 and 4:

This signature is good for one year from the date signed. I can choose an earlier date to terminate this consent or have it end after the event or condition listed below.

Date, event, or condition

SECTION 5 - YOUR CONSENT AND SIGNATURE

Read the statements below, then sign and date the form.

By signing this form below, I understand:

- I am giving consent to share my behavioral health and/or substance use disorder records. This includes referrals and services for alcohol and substance use disorders and/or other information may also be shared.
- My records may be shared with the people or organizations as described above.
- Other types of my health information may be shared along with my behavioral health and substance use disorder records. Under existing laws, my health care provider and health plan do not need my consent to share most types of my health information to treat me, coordinate my care or get paid for care.
- This form does not give my consent to share "psychotherapy notes and/or with substance use disorder counseling notes."
- I can remove my consent to share behavioral health and substance use disorder records at any time. I understand that any records already shared because of past approval cannot be taken back. I should tell all individuals and organizations listed on this form if I remove my consent.
- I have read this form or it has been read to me in a language I can understand. My questions about this form have been answered. I can have a copy of this form.

State your relationship to the person giving consent then sign and date.

☐ Self

☐ Parent (print name) _____

☐ Guardian (print name) _____

☐ Authorized Representative (print name) _____

Signature

Date

→

SECTION 6 - TAKE AWAY YOUR CONSENT, WHO CAN NO LONGER SEE YOUR INFORMATION

I no longer want to share my records with those listed above. I understand any information already shared because of past approval cannot be taken back.

State your relationship to the person withdrawing consent, then sign and date.

☐ Self

☐ Parent (print name) _____

☐ Guardian (print name) _____

☐ Authorized Representative (print name) _____

Signature

Date

→

SECTION 7 - FOR HEALTH CARE PROVIDER OR HEALTH PLAN USE ONLY

Verbal Withdrawal of Consent

List the individual who requested the withdrawal below, then sign and date.

☐ The individual listed in Section 1.

☐ Parent (print name) _____

☐ Guardian (print name) _____

☐ Authorized Representative (print name) _____

Print name of person who received the verbal withdrawal

Signature

Date

→

Other Information for Health Care Providers and Health Plans

This form cannot be used for a release of information for any person or agency that has provided services for domestic violence, sexual assault, stalking, or other crimes. See the FAQ for providers and other organizations at www.michigan.gov/bhconsent.

Additional Identifiers (optional)

Medicaid ID Number

Last four digits of Social Security Number

Form Copy (choose one option)

☐ The individual in Section 1 received a copy of this form.

☐ The individual in Section 1 declined a copy of this form.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

AUTHORITY: This form is acceptable to MDHHS as compliant with 42 CFR Part 2, PA 258 of 1974 and MCL 330.1748 and PA 368 of 1978, MCL 333.1101 et seq. and PA 129 of 2014, MCL 330.1141a.

COMPLETION: Voluntary but required of disclosure is requested.

Section 1 – About You

SECTION 1 - ABOUT YOU

Name (First, Middle Initial and Last)

Mickey Q. Mouse

Date of Birth

11/18/1920



Use the client's full
legal name

Section 2 – TPO

Section 2 allows information to be shared among providers and healthcare plans for care, billing, and coordination

Signing gives ongoing permission for this type of sharing unless expiration is added or consent is withdrawn

Consequences for not providing consent are to be completed by provider

SECTION 2 - TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS (TPO)

Sharing information between individuals and organizations

Consent for All Future Uses for Treatment, Payment, and Health Care Operations

☐ Share all behavioral health and substance use disorder information with all my treating providers, health plans, third-party payers, and people helping to operate this program for treatment, payment, and health care operations.

Expiration for TPO consent: Unless otherwise specified below, this consent does not expire:

☐ This consent expires (optional)

When providing a consent for treatment, payment, and health care operations there is the potential for the records used or disclosed pursuant to the consent to be subject to redisclosure by the recipient and no longer protected by 42 CFR Part 2.

If you do not consent to sharing for treatment, payment, and health care operations the consequences, if any, are Complete this field by including your organization's standard response.

Section 3A – Who Can See Your Info

SECTION 3 - WHO CAN SEE YOUR INFORMATION AND HOW THEY CAN SHARE IT

A. Let us know who can see and share your behavioral health and substance use disorder records. You should list the specific names of health care providers, health plans, family members, or others. They can only share your records with people or organizations listed below.

☒ Health Plan – Blue Cross	☐ Pre-paid Inpatient Health Plan (PIHP) -
1. Easter Seals	2. Suzy Queue, LMSW
3. Mona Mouse (Client's Mom)	4. Jane Doe, MD
5. 	6. 

Family/non-medical
contacts are entered
in this section.

****This example assumes section 2 (TPO) was
NOT signed****

Section 3A – Who Can See Your Info

If Section 2 (TPO) IS signed....

If TPO consent is signed, **only** family members or other non-medical contacts should be listed here. TPO already covers medical-related providers and health plans.

SECTION 3 - WHO CAN SEE YOUR INFORMATION AND HOW THEY CAN SHARE IT

A. Let us know who can see and share your behavioral health and substance use disorder records. You should list the specific names of health care providers, health plans, family members, or others. They can only share your records with people or organizations listed below.

☒ ~~Health Plan – Blue Cross~~

☐ Pre-paid Inpatient Health Plan (PIHP) -

1. ~~Eeaster Seals~~

2. ~~Suzy Queue, LMSW~~

3. ~~Mona Mouse (Client's Mom)~~

4. ~~Jane Doe, MD~~

5.

6.

SECTION 2

VS

SECTION 3

Broad permissions to share information among providers and health plans

Covers providers and organizations involved in treatment, payment, and care coordination (TPO)

Remains active unless an expiration date is added or consent is revoked

Does **not** include individuals/non-medical contacts (family, social services, justice department, etc)



Lists specific people or organizations

Limits sharing to those named

Used when Section 2 is **not** completed for payors and providers, or to include family or non-healthcare individuals

Gives clients more control of information shared

Expires in 1 year unless otherwise specified

Section 3B – How Info Is Shared

B. Sharing Information Electronically

Health information exchanges or networks share records back and forth electronically. This type of sharing helps the people involved in your health care. It helps them provide better, faster, safer, and more complete care for you. Your health care provider and health plan may have already listed these organizations below.

Choose only one option:

- ☒ Share my information through the organizations listed below. This information will be shared (not shared) with the individuals and organizations listed under Section 3a.
- ☐ Do not share my information through the organizations listed below.
- ☐ Share my information through the organizations listed below with all of my past, current, and future treating providers. If I choose this option, I can request a list of providers who have seen my records.

For Health Care Provider or Health Plan Use Only.

List all health information exchanges or networks:

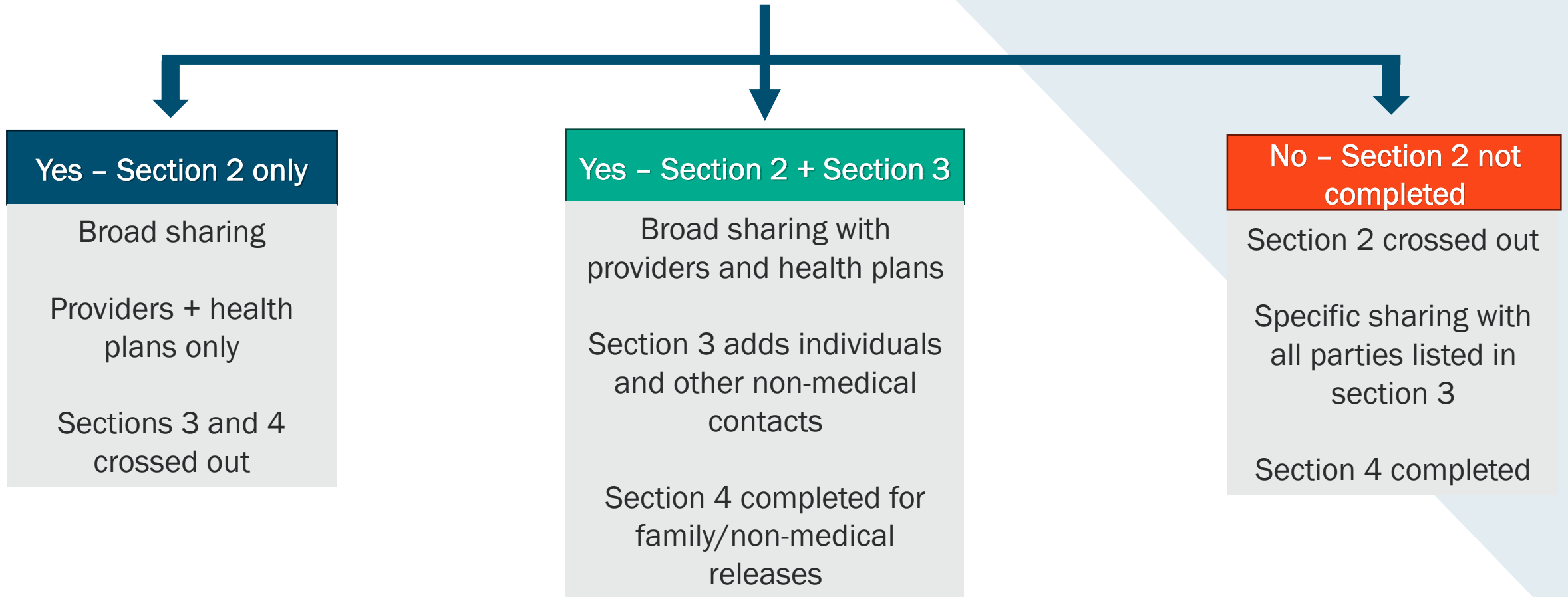
- | | |
|----------|----------|
| 1. OCHIN | 2. MiHIN |
| 3. | 4. |
| 5. | 6. |

Third option allows for future use of the HIE for future treatment providers (ex. emergency room admission notices)

The provider or health plan who has asked the individual to complete the form is responsible for identifying which Health Information Exchanges, Health Information Organizations, and Health Information Networks should be listed on the form.

How Sections 2 and 3 Work Together

Does the client complete Section 2?



Section 4 – What Info is Shared

SECTION 4 - WHAT INFORMATION YOU WANT TO SHARE

Choose one option:

- ☐ Share all my behavioral health and substance use disorder records. This does not include "psychotherapy notes and/or substance use disorder counseling notes."
- ☒ Share only the types of behavioral health and/or substance use disorder records listed above. For example, what I am being treated for, my medications, lab results, etc.

Types of Records

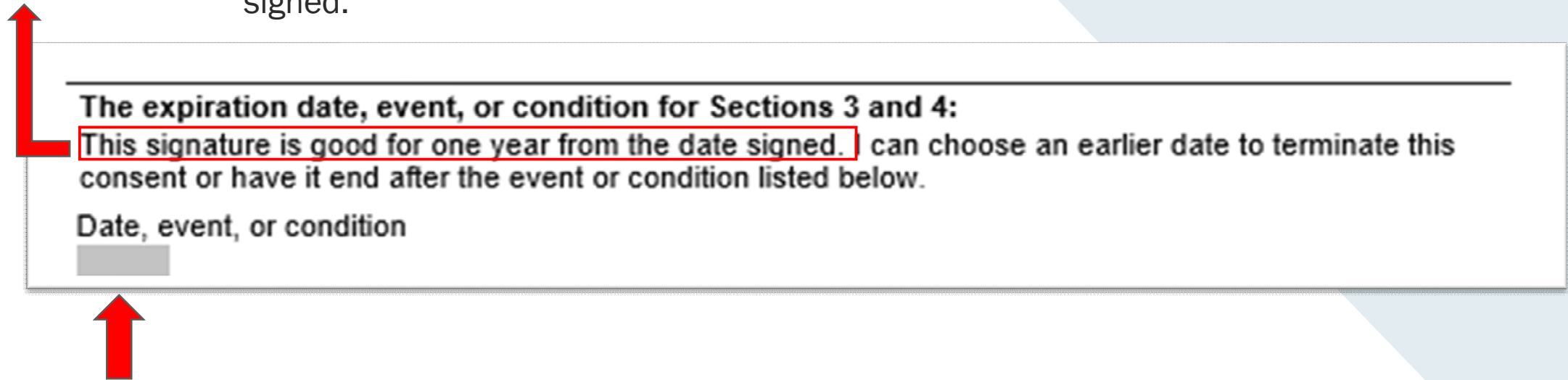
- | | |
|--------------------------------|--------------------|
| 1. Diagnosis | 2. Treatment plans |
| 3. Care plans or service plans | 4. Lab results |
| 5. Discharge summaries | 6. |

All parties listed in Section 3 will receive access to the same information

Follow the minimum-necessary rule to be most protective of patient information

Consent Expiration for Sections 3 + 4

If no date, event, or condition is listed the expiration is set for one year from date signed.



The expiration date, event, or condition for Sections 3 and 4:
This signature is good for one year from the date signed. can choose an earlier date to terminate this consent or have it end after the event or condition listed below.
Date, event, or condition

Clients can list a specific date, event, or condition here to end consent rather than opting for the one-year expiration.

*** Clients may withdraw consent earlier at any time ***

Sections 5 to 7 – Providing OR Revoking Consent

SECTION 5 - YOUR CONSENT AND SIGNATURE

Read the statements below, then sign and date the form.

By signing this form below, I understand:

- I am giving consent to share my behavioral health and/or substance use disorder records. This includes referrals and services for alcohol and substance use disorders and/or other information may also be shared.
- My records may be shared with the people or organizations as described above.
- Other types of my health information may be shared along with my behavioral health and substance use disorder records. Under existing laws, my health care provider and health plan do not need my consent to share most types of my health information to treat me, coordinate my care or get paid for care.
- This form does not give my consent to share "psychotherapy notes and/or with substance use disorder counseling notes."
- I can remove my consent to share behavioral health and substance use disorder records at any time. I understand that any records already shared because of past approval cannot be taken back. I should tell all individuals and organizations listed on this form if I remove my consent.
- I have read this form or it has been read to me in a language I can understand. My questions about this form have been answered. I can have a copy of this form.

State your relationship to the person giving consent then sign and date.

☐ Self

☐ Parent (print name)

☐ Guardian (print name)

☐ Authorized Representative (print name)

Signature

Date 03/16/2026

Section 6 = written withdrawal by the client

SECTION 6 - TAKE AWAY YOUR CONSENT, WHO CAN NO LONGER SEE YOUR INFORMATION

I no longer want to share my records with those listed above. I understand any information already shared because of past approval cannot be taken back.

State your relationship to the person withdrawing consent, then sign and date.

☐ Self

☐ Parent (print name)

☐ Guardian (print name)

☐ Authorized Representative (print name)

Signature

→

Date

Section 7 = provider documentation of verbal withdrawal by client

SECTION 7 - FOR HEALTH CARE PROVIDER OR HEALTH PLAN USE ONLY

Verbal Withdrawal of Consent

List the individual who requested the withdrawal below, then sign and date.

☐ The individual listed in Section 1.

☐ Parent (print name)

☐ Guardian (print name)

☐ Authorized Representative (print name)

Print name of person who received the verbal withdrawal

Signature

→

Date

Identifiers and Form Copies



Other Information for Health Care Providers and Health Plans

This form cannot be used for a release of information for any person or agency that has provided services for domestic violence, sexual assault, stalking, or other crimes. See the FAQ for providers and other organizations at www.michigan.gov/bhconsent.

Additional Identifiers (optional)

Medicaid ID Number

Last four digits of Social Security Number

Form Copy (choose one option)

- ☐ The individual in Section 1 **received** a copy of this form.
- ☐ The individual in Section 1 **declined** a copy of this form.



Scenario 1 – Provider Sharing and Parent Access

A primary care provider is working with a client who receives behavioral health services. The client would like their providers and health plan to be able to share information for care coordination and also would like their parents to be able to access some of their information.

MDHHS-5515, CONSENT TO SHARE BEHAVIORAL HEALTH INFORMATION

Michigan Department of Health and Human Services (MDHHS)

(Revised 9-25)

Use this form to give or take away your consent to share information about your:

- Mental and behavioral health services. This will be referred to as "behavioral health" throughout this form.
- Diagnosis, referral, and treatment for an alcohol or substance use disorder. This will be referred to as "substance use disorder" throughout this form.

This information will be shared to help diagnose, treat, manage, and pay for your health needs.

If using this form for multiple party disclosures, all information identified will be shared with all parties identified on this form. If this is not the goal, use separate forms.

Why This Form Is Needed

When you receive health care, your health care provider and health plan keep records about your health and the services you receive. This information becomes a part of your medical record. Under state and federal laws, your health care provider and health plan do not need your consent to share most types of your health information to treat you, coordinate your care, or get paid for your care. But they may need your consent to share your behavioral health or substance use disorder records.

Instructions

To give consent, fill out Sections 1, and then fill out either section 2 Treatment, Payment, and Healthcare Operations (TPO) only, sections 3 and 4 only or sections 2, 3 and 4.

This consent will not be used for any civil, criminal, administrative, or legislative proceedings.

To take away consent, fill out Section 6.

Sign the completed form, then give it your health care provider. They can make a copy for you.

SECTION 1 - ABOUT YOU

Name (First, Middle Initial and Last)

Alex Johnson

Date of Birth

11/18/2006

SECTION 2 - TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS (TPO)

Sharing information between individuals and organizations

Consent for All Future Uses for Treatment, Payment, and Health Care Operations

- ☒ Share all behavioral health and substance use disorder information with all my treating providers, health plans, third-party payers, and people helping to operate this program for treatment, payment, and health care operations.

Expiration for TPO consent: Unless otherwise specified below, this consent does not expire.

- ☒ This consent expires (optional) 11/18/2029

When providing a consent for treatment, payment, and health care operations there is the potential for the records used or disclosed pursuant to the consent to be subject to redisclosure by the recipient and no longer protected by 42 CFR Part 2.

If you do not consent to sharing for treatment, payment, and health care operations the consequences, if any, are

SECTION 3 - WHO CAN SEE YOUR INFORMATION AND HOW THEY CAN SHARE IT

A. Let us know who can see and share your behavioral health and substance use disorder records. You should list the specific names of health care providers, health plans, family members, or others. They can only share your records with people or organizations listed below.

☐ Health Plan -

☐ Pre-paid Inpatient Health Plan (PIHP) -

1. Tracy Johnson (Mother)

2. Mark Johnson (Father)

3.

4.

5.

6.

B. Sharing Information Electronically

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Choose only one option:

- ☒ Share my information through the organizations listed below. This information will be shared (not shared) with the individuals and organizations listed under Section 3a.
- ☐ Do not share my information through the organizations listed below.
- ☐ Share my information through the organizations listed below with all of my past, current, and future treating providers. If I choose this option, I can request a list of providers who have seen my records.

For Health Care Provider or Health Plan Use Only.

List all health information exchanges or networks:

1. OCHIN

2. MiHIN

3.

4.

5.

6.

SECTION 4 - WHAT INFORMATION YOU WANT TO SHARE

Choose one option:

- ☐ Share all my behavioral health and substance use disorder records. This does not include "psychotherapy notes and/or substance use disorder counseling notes."
- ☒ Share only the types of behavioral health and/or substance use disorder records listed above. For example, what I am being treated for, my medications, lab results, etc.



Types of Records

1. Diagnosis

2. Medications

3. Dates of service

4. Treatment plans

5.

6.

The expiration date, event, or condition for Sections 3 and 4:

This signature is good for one year from the date signed. I can choose an earlier date to terminate this consent or have it end after the event or condition listed below.



Scenario 2 – Care Coordination Across Providers

A Federally Qualified Health Center (FQHC) is providing primary care services to a client who is also receiving behavioral health and SUD treatment. The client would like their providers to be able to coordinate care across services but does not want to sign section 2.

MDHHS-5515, CONSENT TO SHARE BEHAVIORAL HEALTH INFORMATION

Michigan Department of Health and Human Services (MDHHS)

(Revised 9-25)

Use this form to give or take away your consent to share information about your:

- Mental and behavioral health services. This will be referred to as "behavioral health" throughout this form.
- Diagnosis, referral, and treatment for an alcohol or substance use disorder. This will be referred to as "substance use disorder" throughout this form.

This information will be shared to help diagnose, treat, manage, and pay for your health needs.

If using this form for multiple party disclosures, all information identified will be shared with all parties identified on this form. If this is not the goal, use separate forms.

Why This Form Is Needed

When you receive health care, your health care provider and health plan keep records about your health and the services you receive. This information becomes a part of your medical record. Under state and federal laws, your health care provider and health plan do not need your consent to share most types of your health information to treat you, coordinate your care, or get paid for your care. But they may need your consent to share your behavioral health or substance use disorder records.

Instructions

To give consent, fill out Sections 1, and then fill out either section 2 Treatment, Payment, and Healthcare Operations (TPO) only, sections 3 and 4 only or sections 2, 3 and 4.

This consent will not be used for any civil, criminal, administrative, or legislative proceedings.

To take away consent, fill out Section 6.

Sign the completed form, then give it your health care provider. They can make a copy for you.

SECTION 1 - ABOUT YOU

Name (First, Middle Initial and Last)	Date of Birth
Jane Doe	02/15/1993

SECTION 2 - TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS (TPO)

Sharing information between individuals and organizations

Consent for All Future Uses for Treatment, Payment, and Health Care Operations

- ☒ Share all behavioral health and substance use disorder information with all my treating providers, health plans, third-party payers, and people helping to operate this program for treatment, payment, and health care operations.

Expiration for TPO consent: Unless otherwise specified below, this consent does not expire.

☐ This consent expires (optional) _____

When providing a consent for treatment, payment, and health care operations there is the potential for the records used or disclosed pursuant to the consent to be subject to redisclosure by the recipient and no longer protected by 42 CFR Part 2.

If you do not consent to sharing for treatment, payment, and health care operations the consequences, if any, are _____

SECTION 3 - WHO CAN SEE YOUR INFORMATION AND HOW THEY CAN SHARE IT

A. Let us know who can see and share your behavioral health and substance use disorder records. You should list the specific names of health care providers, health plans, family members, or others. They can only share your records with people or organizations listed below.

- | | |
|---|--|
| ☒ Health Plan - Great Lakes Health Plan | ☐ Pre-paid Inpatient Health Plan (PIHP) - _____ |
| 1. Lakeshore Family Health Center (FQHC) | 2. Northstar Behavioral Health Clinic |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

B. Sharing Information Electronically

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Choose only one option:

- ☒ Share my information through the organizations listed below. This information will be shared (not shared) with the individuals and organizations listed under Section 3a.
- ☐ Do not share my information through the organizations listed below.
- ☐ Share my information through the organizations listed below with all of my past, current, and future treating providers. If I choose this option, I can request a list of providers who have seen my records.

For Health Care Provider or Health Plan Use Only.

List all health information exchanges or networks:

- | | |
|----------|----------|
| 1. OCHIN | 2. MIHIN |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

SECTION 4 - WHAT INFORMATION YOU WANT TO SHARE

Choose one option:

- ☒ Share all my behavioral health and substance use disorder records. This does not include "psychotherapy notes and/or substance use disorder counseling notes."
- ☐ Share only the types of behavioral health and/or substance use disorder records listed above. For example, what I am being treated for, my medications, lab results, etc.

Types of Records

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

The expiration date, event, or condition for Sections 3 and 4:

This signature is good for one year from the date signed. I can choose an earlier date to terminate this consent or have it end after the event or condition listed below.



Scenario 3 – Care Coordination with Parole Involvement

An opioid treatment program is helping a client complete the MDHHS-5515. The client has already completed a separate consent form for care coordination and insurance purposes. The client now needs to provide proof of treatment to a parole officer but only wants to share confirmation of care.

Coordination for Justice-Involved Individuals

1. The 5515 **CAN** be used for care coordination purposes between providers, payors, and the justice system
2. A separate 5515 from **MUST** be completed for this purpose – no other parties can be listed on the form
 - Section 2 (TPO) is not applicable and must be skipped
 - Complete Sections 3-5 as done with previous versions of the form with the focus on minimum necessary information shared
3. Records disclosed to the justice system (from the completed 5515) can't be used against the patient in civil, criminal, administrative, or legislative proceedings without a qualifying court order
 - Continue to follow existing processes/procedures to obtain information that would be legally permissible



MDHHS-5515, CONSENT TO SHARE BEHAVIORAL HEALTH INFORMATION

Michigan Department of Health and Human Services (MDHHS)

(Revised 9-25)

Use this form to give or take away your consent to share information about you:

- Mental and behavioral health services. This will be referred to as "behavioral health" throughout this form.
- Diagnosis, referral, and treatment for an alcohol or substance use disorder. This will be referred to as "substance use disorder" throughout this form.

This information will be shared to help diagnose, treat, manage, and pay for your health needs.

If using this form for multiple party disclosures, all information identified will be shared with all parties identified on this form. If this is not the goal, use separate forms.

Why This Form Is Needed

When you receive health care, your health care provider and health plan keep records about your health and the services you receive. This information becomes a part of your medical record. Under state and federal laws, your health care provider and health plan do not need your consent to share most types of your health information to treat you, coordinate your care, or get paid for your care. But they may need your consent to share your behavioral health or substance use disorder records.

Instructions

To give consent, fill out Sections 1, and then fill out either section 2 Treatment, Payment, and Healthcare Operations (TPO) only, sections 3 and 4 only or sections 2, 3 and 4.

This consent will not be used for any civil, criminal, administrative, or legislative proceedings.

To take away consent, fill out Section 6.

Sign the completed form, then give it your health care provider. They can make a copy for you.

SECTION 1 - ABOUT YOU

Name (First, Middle Initial and Last)	Date of Birth
John Smith	05/02/1976

SECTION 2 - TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS (TPO)

Sharing information between individuals and organizations

Consent for All Future Uses for Treatment, Payment, and Health Care Operations

- ☐ Share all behavioral health and substance use disorder information with all my treating providers, health plans, third-party payers, and people helping to operate this program for treatment, payment, and health care operations.

Expiration for TPO consent: Unless otherwise specified below, this consent does not expire.

- ☐ This consent expires (optional) _____

When providing a consent for treatment, payment, and health care operations there is the potential for the records used or disclosed pursuant to the consent to be subject to redisclosure by the recipient and no longer protected by 42 CFR Part 2.

If you do not consent to sharing for treatment, payment, and health care operations the consequences, if any, are _____

SECTION 3 - WHO CAN SEE YOUR INFORMATION AND HOW THEY CAN SHARE IT

A. Let us know who can see and share your behavioral health and substance use disorder records. You should list the specific names of health care providers, health plans, family members, or others. They can only share your records with people or organizations listed below.

- | | |
|--|--|
| ☐ Health Plan – _____ | ☐ Pre-paid Inpatient Health Plan (PIHP) - _____ |
|--|--|

1. Officer Daniel Harris, Michigan Dept. of Corrections - Parole

2. _____

3. _____

4. _____

5. _____

6. _____

B. Sharing Information Electronically

Health information exchanges or networks share records back and forth electronically. This type of sharing helps the people involved in your health care. It helps them provide better, faster, safer, and more complete care for you. Your health care provider and health plan may have already listed these organizations below.

Choose only one option:

- ☐ Share my information through the organizations listed below. This information will be shared (not shared) with the individuals and organizations listed under Section 3a.
- ☐ Do not share my information through the organizations listed below.
- ☐ Share my information through the organizations listed below with all of my past, current, and future treating providers. If I choose this option, I can request a list of providers who have seen my records.

For Health Care Provider or Health Plan Use Only.

List all health information exchanges or networks:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

SECTION 4 - WHAT INFORMATION YOU WANT TO SHARE

Choose one option:

- ☐ Share all my behavioral health and substance use disorder records. This does not include "psychotherapy notes and/or substance use disorder counseling notes."

- ☒ Share only the types of behavioral health and/or substance use disorder records listed above. For example, what I am being treated for, my medications, lab results, etc.

Types of Records

1. Confirmation of enrollment

2. Confirmation of program compliance

3. _____

4. _____

5. _____

6. _____

The expiration date, event, or condition for Sections 3 and 4:

This signature is good for one year from the date signed. I can choose an earlier date to terminate this consent or have it end after the event or condition listed below.

Resources

- [MDHHS 5515 Resource Page](#)
 - 1-Page Handout for Consumers
 - FAQs – Patients
 - FAQs – Providers
- [FOCUS PHI](#) – Center of Excellence for Protected Health Information
 - [eLearning Module: Privacy Basics for Frontline Staff](#)
 - [Let's Talk – For Substance Use Treatment Providers](#)
- [Law Enforcement Access to Additional Treatment Records Protected by Federal Privacy Laws](#)



Please complete the short survey to
help us improve this training!

Coming in FY 2027

- On-demand Learning Module on the 5515 Form basics (30 min)
 - Will be available through [Improvingmipractice.org](https://improvingmipractice.org)
 - CEUs available for social workers and MCBAP professionals
- Office Hours/Learning Series
 - Offered bi-monthly for all providers
 - Look out for information for registering

Questions?
Please email
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