Consent for the Release of Information under 42 C.F.R. PART 2 **Confidentiality of Substance Use Disorder Patient Records**

I, authorize	
I,authorize(Name of patient) (Name of provider)	
Information to be disclosed I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), mental health and substance use. I authorize the release or disclosure of the substance use disorder records below:	
☐ All my substance use disorder records;	
or only the following specific types of records	
□Attendance □Toxicology Results □Medication(s)/dosing □Assessments □Pr	ogress in Treatment
□Treatment plan □Lab results □Appointments □Diagnostic information □Insurance in	nfo/demographics
□ Discharge Summary □ Substance Use History □ Trauma History Summary □ Other:	
To:	
(Name of person or organization to which disclosure is to be made)	
Phone: Fax:	
For (purpose of disclosure): □Continuity of Care □Coordinating Treatment □ Payment/benefits administration	
□ Other:	
I understand that my substance use disorder patient records are protected under federal regular Confidentiality of Substance Use Disorder Patient Records and cannot be disclosed without not need to sign this form to obtain treatment. I may revoke this consent in writing at any time revocation will not be effective retroactively for information disclosures that have already or revoked, this consent will terminate either:	at my written consent. I do ne. I understand that the ccurred. If not previously
upon a specific date, event, or condition as listed here: (Specific date, event or condition)	
	,
Patient's Signature: Date: If the patient is a minor, only the minor can sign this consent.	
Print Name Date of Birth (MM/DD/YY) Me	edical Record Number
If the individual is unable to sign due to legal incapacity, the signature of the individual's is required. Documentation of the personal representative's legal authority must be attached	
Signature of Personal Representative: Date:	
Legal Authority:	
By signing below, I am revoking this Consent for the Release of Confidential Health Information.	
Patient Revocation: Date:	
NOTICE TO RECIPIENT OF INFORMATION	
42 CFR part 2 prohibits unauthorized disclosure of these records.	

Notice of Federal Requirements Regarding the Confidentiality of Substance Use Disorder Patient Information

The confidentiality of substance use disorder patient records maintained by this program is protected by federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser <u>unless</u>:

- 1. The patient consents in writing; **or**
- 2. The disclosure is allowed by a court order accompanied by a subpoena; or
- 3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation; **or**
- 4. The patient commits or threatens to commit a crime either at the program or against any person who works for the program,

Violation of federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

The releases of information will remain active and valid for one year from the date of signature OR until 90 days after discharge (whichever comes first) OR until a specific date, event, or condition as listed on the form. There are two ways to revoke a release of information: Come in to the BrightView facility where you were scheduled to receive treatment and sign the revocation, or fax in a written statement with your name, signature, date and release(s) you would like to be revoked.

(See 42 U.S.C. §290dd-2 for federal law and 42 C.F.R. Part 2 for federal regulations governing Confidentiality of Substance Use Disorder Patient Records.)