



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

I, _____, _____
CLIENT NAME DATE OF BIRTH (MM/DD/YYYY)

hereby authorize BrightView, LLC to release/disclose the information below:

Are you involved with the court system (i.e., Civil, Criminal, Probation, Child Protective Services)?

- Yes (skip to "For Justice System Patients Only" section)
- No

Name of person/organization/provider (to whom we are releasing information for):

Contact information (Phone number, fax, email. If unknown, add N/A.):

FOR JUSTICE SYSTEM PATIENTS ONLY

Note: Contact information for at least one of these individuals is required.

_____ JUDGE	_____ JUDGE CONTACT PHONE NO., FAX NO., EMAIL, OR N/A
_____ PROBATION/PAROLE AUTHORITY (OFFICE/DEPT.)	_____ PROBATION CONTACT PHONE NO., FAX NO., EMAIL, OR N/A
_____ DEFENSE ATTORNEY	_____ DEFENSE ATTORNEY CONTACT PHONE NO., FAX NO., EMAIL, OR N/A
_____ PROSECUTING ATTORNEY	_____ PROS. ATTORNEY CONTACT PHONE NO., FAX NO., EMAIL, OR N/A
_____ CHILD PROTECTIVE SERVICES	_____ CPS CONTACT PHONE NO., FAX NO., EMAIL, OR N/A
_____ OTHER	_____ OTHER CONTACT PHONE NO., FAX NO., EMAIL, OR N/A

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 disclose of the records below:

All records (i.e., all categories of records listed below)

Or only the following specific types of records (check each category that applies):

- | | | |
|----------------------------------|---------------------------|----------------------|
| Appointments | Discharge Summary | Medication(s)/Dosing |
| Attendance | Insurance Information | Referral Information |
| Behavioral Health Assessments | Lab Results | Toxicology Results |
| Behavioral Health Progress Notes | Medical Progress Notes | Treatment Plans |
| Diagnosis | Medical Psychiatric Notes | Other: _____ |

Date of information to be disclosed (when end date is specified as "current," this indicates expiration date or revocation date of ROI):

All dates of service _____ Specific dates, start: _____ end: _____
MM/DD/YYYY MM/DD/YYYY

Purpose of disclosure:

Continuity of Care _____ Coordinating Treatment _____ Legal _____
Payment/Benefits _____ Other: _____

I understand that my substance use disorder patient records are protected under federal regulations 42 C.F.R. Part 2 Confidentiality of Substance Use Disorder Patient Records and cannot be disclosed without my written consent. I do not need to sign this form to obtain treatment. I may revoke this consent in writing at any time. I understand that the revocation will not be effective retroactively for information disclosures that have already occurred.

I understand that generally BrightView may not condition my treatment on whether I sign a consent form, but in certain limited circumstances, I may be denied treatment if I do not sign a consent form.

If not previously revoked, this consent will terminate:

In one year from the date of signature OR 90 days after discharge (whichever comes first); OR

Upon a specific date, event, or condition as listed here: _____

SIGNATURE OF PATIENT

PATIENT'S SIGNATURE DATE (MM/DD/YYYY)

PRINT NAME

SIGNATURE OF PERSONAL REPRESENTATIVE

PERSONAL REPRESENTATIVE'S SIGNATURE DATE (MM/DD/YYYY)

PRINT NAME LEGAL AUTHORITY

REVOKING CONSENT

By signing below, I am revoking this Consent for Release of Confidential Health Information Patient Revocation:

PATIENT'S SIGNATURE DATE (MM/DD/YYYY)

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 unless:

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 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.)

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