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
- ☐ Attendance
- ☐ Behavioral Health Assessments
- ☐ Behavioral Health Progress Notes
- ☐ Diagnosis
- ☐ Discharge Summary
- ☐ Insurance Information
- ☐ Lab Results
- ☐ Medical Progress Notes
- ☐ Medical Psychiatric Notes
- ☐ Medication(s)/Dosing
- ☐ Referral Information
- ☐ Toxicology Results
- ☐ Treatment Plans
- ☐ 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: _____ (MM/DD/YYYY) end: _____ (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.)

BrightView, LLC | 4600 Montgomery Rd., Cincinnati, OH 45212 | Phone: 833.510.HELP (4357) | Fax: 513.547.4109