Consent for Uses and Disclosures of PHI and/or Part 2 Covered Information

PATIENT NAME: _____ **DATE:** _____

DATE OF BIRTH (MM/DD/YYYY)_____

☐ I understand that my substance use disorder treatment records are protected under federal law, including 42 CFR Part 2, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the implementing regulations thereto, 45 CFR Parts 160 & 164, and any applicable state laws. My treatment records can only be used or disclosed with my written consent, except as permitted by 42 CFR Part 2, HIPAA, and applicable state law.

☐ **I understand that I have the right not to sign this consent form**, and that I may revoke my consent at any time. However, I understand that the program may need to make certain disclosures in order to operate its health care business, and if I refuse my consent to disclosures solely for the purposes of treatment, payment, or healthcare operations, the program may be unable to provide me with further treatment. Such consent shall be made pursuant to any reasonable restrictions on uses and disclosures requested by you, the patient, and agreed to by the program.

AUTHORIZATION

☐ **I authorize the following person or types of people to use and disclose my records:**

Facility/Individual Name: _____

Phone Number: (____) ____-_____ Fax: (____) ____-_____

Address:_____

Email Address: _____

☐ **I authorize the following person or groups of people to receive my records:**
Facility/Individual Name: _____

Phone Number: (____) ____-_____ Fax: (____) ____-_____

Address: _____

Email Address: _____

– **OR** – the following groups or classes of people:

◯ **TPO:** *My treating providers, health plans, third-party payers, and persons helping to operate the program*.

RECORDS TO BE USED AND DISCLOSED. I authorize the following information to be used or disclosed:

☐ Complete Clinical Record ***(other than SUD Counseling Notes- see below)***

☐ Admission/discharge summaries	☐ History/Physical	☐ Medication lists and monitoring
☐ Physicians Orders	☐ Progress Notes	☐ Psychiatric Evaluations
☐ Psychosocial Assessments	☐ Treatment Plans	☐ Physician Orders
☐ Diagnostic Reports	☐ Laboratory/Diagnostic results	☐ Financial Records
☐ Psychosocial	☐ Other (Specify): _____	☐ All of the above

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☐ **Psychotherapy/SUD COUNSELING NOTES:** I agree to the use and disclosure of my psychotherapy notes (as that term is defined by 42 C.F.R. § 164.501) if this box is checked, no other record types may be combined with this disclosure.
☐ and/or substance use disorder (SUD) counseling notes (as defined at 42 C.F.R. § 2.11). I am not required to check this box as a condition of treatment, payment, enrollment in a health plan, or eligibility for benefits. **If this box is checked, no other record types may be combined with this disclosure.**

PURPOSE. I authorize uses and disclosures for the following purpose(s) only:

☐ Treatment, Payment, and Healthcare Operations (TPO) ☐ Patient Request ☐ Employment
☐ School ☐ Other: _____

☐ **LEGAL PROCEEDINGS:** I agree to the use and disclosure of my substance use disorder treatment records to be used in the criminal, civil, legislative, or administrative proceeding identified below**. If this box is checked, no other purposes may be combined with this disclosure.**

List Case/Investigation No. (if known), or description of proceedings if unknown:

_____

EFFECT. I understand that if HIPAA-covered entities and business associates receive these records for treatment, payment, and health care operations purposes, **the records may be redisclosed in accordance with HIPAA, except for uses or disclosures for civil, criminal, administrative, or legislative proceedings against me**.

TIME PERIOD. Unless I revoke my consent, this consent will take effect immediately and expire on _____. However, if I am giving my consent for the purposes of treatment, payment, and healthcare operations, or if I have not designated a date certain, then my consent shall expire one (1) year after the end of treatment.

I have the right to revoke this consent in writing at any time. I understand, however, that actions and disclosures may have already been taken in reliance on my consent and that my revocation is not effective with respect to prior acts. I understand that I may revoke consent by contacting Miramont Health Information Department at HIM@MiramontBH.com.

I have been offered a copy of this form. It has been explained to me in language I understand. ***I acknowledge that there is a potential for the records used or disclosed pursuant to this consent to be subject to redisclosure by the recipient and no longer protected by Part 2***.

Signature of Patient: _____ **Date**: ___/___/____
Signature of Other Authorized Person: _____
Name: _____ **Date**: ___/___/____
Relationship to the Patient: _____
WITNESS NAME: _____ DATE: ___/___/____

42 CFR PART 2 PROHIBITS UNAUTHORIZED USE OR DISCLOSURE OF THESE RECORDS.