TPO Consent for Disclosure of
Patient Identifying Information and Substance Use Disorder Patient Records

A. PATIENT INFORMATION

_____
Patient's name (*please print*):

_____ _____
Health Plan ID#: Date of Birth:

_____
Address:

_____
City/State/Zip

_____ _____
Phone number E-Mail address

B. PERSONS PERMITTED TO MAKE DISCLOSURES

_____("Provider")
Name of Part 2 Program (*i.e.*, provider furnishing treatment to patient)

_____("Third Party Payer/Heath Plan")
Name of Third Party Payer/Health Plan (i.e. entity providing health benefits coverage)

C. RECIPIENT OF AND PURPOSE FOR DISCLOSURE

1. Provider may disclose Patient Identifying Information about me to my treating health care providers, the Third Party Payer/Health Plan, other third-party payers, and their business associates (vendors) for the Provider's treatment, payment, and health care operations.
2. Third Party Payer/Health Plan may redisclose Patient Identifying Information as permitted by the HIPAA Privacy Rule, including (but not limited to) for treatment, payment, and health care operations, ***except that***: the information cannot be used or disclosed for civil, criminal, administrative, or legislative proceedings against me.

D. INFORMATION THAT MAY BE DISCLOSED

All information necessary to process my claims and coordinate my care may be disclosed. This may include (among other information) diagnoses (names of illnesses or conditions), procedures (type of treatments), my prescriptions, dates of treatment, and names of health care practitioners or other providers who treat me.

E. EXPIRATION OR REVOCATION OF CONSENT

1. This consent will expire one (1) year after you disenroll from your health plan.
2. You may revoke this consent at any time by contacting the Third Party Payer/Health Plan or Provider at the address provided below. Your revocation will not be effective, however, to the extent that the Third Party Payer/Health Plan or Provider or others have already acted in reliance on the consent.

F. IMPORTANT INFORMATION ABOUT THIS CONSENT

Although the Patient Identifying Information and information described above will continue to be protected by the HIPAA Privacy Rule, once Provider discloses information as permitted by this consent, the information will no longer be protected by the Confidentiality of Substance Use Disorder Patient Records Rule (Part 2).

If you do not sign this consent, however, Third Party Payer/Health Plan cannot pay claims for your treatment because it will not be allowed to use or disclose information about you.

G. SIGNATURE AND DATE

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

By signing below, I expressly consent to the disclosures detailed above.

_____

Signature of Patient

_____

Signature of person authorized to provide consent under Part 2, if applicable.

_____

Relationship of person authorized to provide consent, if applicable.

_____

Today’s Date

TO REVOKE THIS CONSENT, YOU MAY CONTACT
THE PROVIDER
OR
THE THIRD PARTY PAYER/HEALTH PLAN