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 Email address

B. PERSONS PERMITTED TO MAKE DISCLOSURES

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

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

C. PURPOSE FOR DISCLOSURE

1. Provider may disclose Patient Identifying Information to the Third-Party Payer/Health Plan for the Third Party Payer/Health Plan's payment and health care operations activities.
2. Third Party Payer/Health Plan may disclose Patient Identifying Information to the Provider for the Provider's payment and health care operations activities.

D. 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 authorization at any time by writing 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 has acted in reliance on the consent.

E. 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