MID-STATE HEALTH CENTER

AUTHORIZATION AND CONSENT TO DISCLOSE PART 2 PROGRAM INFORMATION (SUBSTANCE USE DISORDER SERVICES)

Section I - Patient			
First Name	**M.I.**	**Last Name**	**Date of Birth**
Address	**City**	**State**	**Zip Code**

Section II – To Whom: Provider/ Agency Recipient and Purpose

_____ I authorize my treatment team to disclose information relating to substance use disorder and mental health treatment records, both verbally and in writing, to and from my past, current, and/ or future treating providers at Mid-State Health Center and elsewhere. The purpose of this information is for ***my ongoing treatment and recovery and helping me manage my care***. These treatment provider(s) and/ or entity(-ies) include:

A. Provider/ Entity		Telephone Number	
Address	City	State	Zip Code

The information to be provided:

☐ _____ My health care record
☐ _____ Evaluations and assessments by providers
☐ _____ Test(s), Lab(s) and/ or Radiology results
☐ _____ Medications
☐ _____ Case Management and Treatment Plans (including and medical record Addendums)
☐ _____ Other: ____

Specify time period, if desired:
Release only information from the period ________________ *(mm/dd/yyyy)* to _______________ *(mm/dd/yyyy)*

Purpose:

☐ Transportation
☐ Monitoring and supporting my ongoing recovery
☐ Assessing/ evaluating my readiness/ ability to participate in housing/ employment/ vocational training/ etc.
☐ Confirming compliance with court ordered treatment, probation or parole
☐ For the purposes of the care and treatment of my children
☐ Other: ____

B. Provider/ Entity		Telephone Number	
Address	City	State	Zip Code

The information to be provided:

☐ _____ My health care record
☐ _____ Evaluations and assessments by providers
☐ _____Test(s), Lab(s) and/ or Radiology results
☐ _____ Medications
☐ _____ Case Management and Treatment Plans (including and medical record Addendums)
☐ _____ Other: ____

Specify time period, if desired:
Release only information from the period ________________ *(mm/dd/yyyy)* to _______________ *(mm/dd/yyyy)*

Purpose:

☐ Transportation
☐ Monitoring and supporting my ongoing recovery
☐ Assessing/ evaluating my readiness/ ability to participate in housing/ employment/ vocational training
☐ Confirming compliance with court ordered treatment, probation or parole
☐ For the purposes of the care and treatment of my children

☐ Other: ____

Section III – Billing/ Payment

_____ I authorize my Substance Use Disorder treatment team to use, disclose, and communicate both verbally and in writing any and all information about my care and treatment to and from my health insurance company and other entity responsible for my medical bills for the purposes of eligibility and payment:

Insurance Carrier (or other entity):	Telephone Number	Member ID
Insurance Carrier (or other entity):	Telephone Number	Member ID

Section IV – Family/ Friends/ Advocates:

_____ I authorize my Mid-State Health Center's affiliated treating providers and staff to discuss my relevant heath information, including my substance use disorder and mental health treatment, with the family members, friends, and/or advocates named below: (Please provide **full name** of authorized individuals)

A. Name	Relationship	Telephone Number
B. Name	Relationship	Telephone Number
C. Name	Relationship	Telephone Number

Section V - Expiration

This authorization will remain in effect until revoked or shall expire on date or event specified below.
I understand that I may revoke or cancel this authorization at any time by submitting written revocation in the manner specified by the disclosing entity, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will expire on the date or completion of the event stated below. If no date or event is specified below, this authorization will expire in one year.

Expiration Date or Event: ____________________ *(mm/dd/yyyy)*

Section VI – Acknowledgement of Rights

• I understand that my substance use disorder treatment records are protected under the federal regulations relating to Confidentiality and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise outlined in the regulations. I understand that if my treatment team discloses my substance use disorder treatment records outlined in this consent, the recipient of my information will receive a notice of non-disclosure.
• Upon request, I can inspect or obtain a copy of the information I am authorizing to be released. I understand that I may be denied services if I refuse to consent to a disclosure for purposes of ***my treatment or payment***. I will not be denied services if I refuse to consent to a disclosure for other purposes.
• If I have any questions about disclosure of my private health information, I can contact the Compliance Officer at 603.536.4000 Ext.1003. I understand I can request a copy of this authorization and consent form by calling Mid-State Health Center's Health Information Management at 603.536.4000 Ext. 1500 and completing the Patient Record Request form.

Signature of Individual	**Date** *(mm/dd/yyyy)*
Signature of Personal Representative (if applicable)	**Date** *(mm/dd/yyyy)*

Relationship of Personal Representative to Individual (P*roof of authority must be on file)*
☐ Parent ☐ Legal Guardian ☐ Healthcare Power of Attorney ☐ Executor/Administrator ☐ Other ☐ N/A

For administrative use only:

Method of Delivery (e.g. paper, fax, electronic,)	Date Released	Staff initials