Elliot Health System
WE ARE SOLUTIONHEALTH

Consent to Release Substance Use Disorder Information

REMEMBER: Information disclosed pursuant to patient consent must be accompanied by the notice prohibiting re-disclosure

PATIENT IDENTIFICATION:

I____, born on ____
hereby authorize__________________________

(name of individual or entity/program)

PATIENT INFORMATION TO BE RELEASED:

to disclose the following information: ***All of my substance use disorder information*** or the following selected information:

☒ Intake, progress and discharge reports and notes ☒ Medications ☒ Referrals for treatment

☒ Evaluations and assessments by my providers ☒ Case management notes ☒ Treatment plans
☒ Urine toxicology tests and results ☐ Other (specify) ________________________________

AUTHORIZATION TO:

To All of my past, present and future treating providers at SolutionHealth and SolutionHealth covered entities and their affiliates__________
AND____
(Name of Health Insurance and/or other entities)

PURPOSE of the disclosure is:

☒ Treatment/Continuity of Care ☒Healthcare Payment ☐Other:____

I UNDERSTAND THAT:

My substance use disorder treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I know that this authorization is voluntary, and I may refuse to sign this form. I understand that refusing to sign this form will not affect my ability to obtain treatment from Elliot Health System, the payment for my treatment, or my enrollment or eligibility for benefits unless allowed by law. I understand that I may revoke this authorization at any time verbally or in writing, except to the extent that action has been taken in reliance on it. Upon request, I am entitled to a list of entities and/or individuals that have received information under this authorization for the past two years as of the date the request is made.

EXPIRATION DATE:

I have read this entire form or have had it read to me. I understand the authorization and herby authorize the release of my patient information stated above. Unless I verbally revoke my authorization earlier, this authorization expires automatically on: ____________________ or ____upon my death______________________________.

Fax Release Notice: I am aware and understand the risks to confidentiality involved in transmission of my substance use disorder information by e-mail and fax and I agree to assume those risks.

____ ____________________________
Patient/Parent/Legal Representative Signature Date

____
Identification (if other than patient)

Date Consent Revoked: ______________________
Provider initials: ____________________________

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INSTRUCTION

How to fill out the Part 2 “Consent to Release Substance Use Disorder Information”

GENERAL

This form must be filled out in order to document in EPIC and to bill insurance companies for Part 2 substance use disorder programs and services. This form should be used for specific credentialed individuals providing treatment at the Partial Hospitalization Program and Elliot Hospital Emergency Department, Medication Assisted Treatment (MAT) programs, and Intensive Outpatient Program (IOP).

PATIENT INFORMATION TO BE RELEASED

This is not an all exclusive list. If there are other types of PHI/documents to be disclose you may handwrite this in the “Other” option.

AUTHORIZATION TO

This section outlines the individual(s) or entity that will be receiving the Part 2 protected PHI. The language to use in this section is dependent on the recipient of the PHI. Multiple consent forms may need to be completed for the patient based on the recipient of the information and the duration of the consent.

If the recipient is:	**Examples**	**Language to Include:**
General Designation	Entering PHI into EPIC	“All of my past, present, and future treating providers at SolutionHealth and SolutionHealth covered entities and their affiliates”
Insurance Company/Third Party Payer	Blue Cross Blue Shield Medicare	Name of the entity
Treating Provider Entity outside of Elliot Health System	Other hospitals, PCPs, other SUD treatment programs	Name of the entity
Non-treating provider entity (not a third party payer)	Law office, court, school, government agency	Name of individual at the entity and the name of the entity

PURPOSE

Please mark the purpose of the disclosure of the information whether it is verbal communication or paper records, i.e. for treatment, payment, or other and handwrite in the other reasons for the disclosure.

EXPIRATION DATE

Please review the date range with the patient. The “upon my death” should be used for information that is entered into Elliot Health System’s electronic medical record, EPIC. Based on the recipient this section may need to be modified and multiple consent forms may need to be completed for the patient.

REVOCATION

Under Part 2 rules patients may verbally revoke consent to use and disclose their PHI. If this occurs staff should note the date of the revocation on the bottom of the consent form and print their name indicating who was notified by the patient. Staff should then send an all staff email to the practice/program alerting team members of the revocation. The consent form with the revocation date should be sent to the HIM Department for scanning into the electronic medical record.