

Consent to Release Substance Use Disorder Part 2 Records

PATIENT MUST BE GIVEN NOTICE OF FEDERAL PRIVACY PROTECTIONS UPON ADMISSION.

Form Instructions: If any section of this form is incomplete, this form may be invalid. Fees may apply to certain requests.

1. Patient Information:			
Name: (First, MI, Last)		Phone:	Date of Birth:
Current Address:		Email:	
City:	State:	Zip:	
2. Health Information FROM		3. Release Information TO (the "Recipient")	
<input type="checkbox"/> Southwest General Oakview Intensive Outpatient (IOP) Program ("Program") for substance use disorder (SUD)		<input type="checkbox"/> For all future treatment, payment, and health care operations such as; my treating providers, health plan(s), third-party payers, and people / entities to operate this IOP Program.	
IMPORTANT NOTE: This consent form is intended only for requests for IOP SUD records. Please use a general authorization form for requests for other medical and billing records.		<input type="checkbox"/> To (name): _____ Address: _____ _____	
4. Delivery Method			
<input type="checkbox"/> Mail (paper copy) OR <input type="checkbox"/> Pick Up (paper copy – please schedule a pickup day and time)			
<i>NOTE: Records ineligible for secure email or fax will be mailed.</i>			
<input type="checkbox"/> Electronic copy via secure email (recipient email required)		Email: _____	
<input type="checkbox"/> Fax - Attention: _____		Fax #: _____	
5. Release information for date(s) FROM: _____ TO: _____ OR <input type="checkbox"/> Release for duration of treatment plan Information to Disclose (please check all appropriate boxes below):			
<input type="checkbox"/> Discharge Information (summaries, instructions, etc)	<input type="checkbox"/> Clinical Notes (progress notes, nurse notes, etc.)	<input type="checkbox"/> Information to comply with court order or referral	<input type="checkbox"/> Verbal health status to family / others involved
<input type="checkbox"/> Information for treatment, payment and operations	<input type="checkbox"/> Consult Notes	<input type="checkbox"/> All IOP SUD records	<input type="checkbox"/> Other (specify): _____
6. Reason / Purpose of disclosure (please check all appropriate boxes below):			
<input type="checkbox"/> Personal (to patient or their personal representative)		<input type="checkbox"/> Health status for others involved in my care	
<input type="checkbox"/> All future treatment, payment, and health care operations		<input type="checkbox"/> Criminal Justice System referral	
<input type="checkbox"/> Social Security / Disability / FMLA		<input type="checkbox"/> Legal proceedings / Court Order (consent cannot be combined with any other consent for use or disclosure)	
<input type="checkbox"/> Other (specify): _____			

This authorization will expire:

Enter date or event here: _____ Upon completion of Treatment Until Revoked by Patient

I, the undersigned, authorize Southwest General to disclose the Part 2-protected health information described in Section 5 above for the purpose described in Section 6 above. This consent may be revoked in writing to the Medical Records Department (address below). I understand revocation will not apply to information that has already been shared in response to this consent. I understand my SUD records are protected by federal privacy regulations (42 CFR Part 2 and HIPAA 45 CFR Parts 160 and 164) and cannot be re-disclosed, without my written consent unless otherwise permitted or required by law (e.g., medical emergency; court order). However, records disclosed to lawful holders under general consent for purposes of all future treatment, payment, and health care operations may be re-disclosed only pursuant to the HIPAA regulations and may no longer be protected by Part 2 regulations, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against the patient.

I understand I may be denied services if I refuse to consent to use and disclosure for purposes of treatment, payment, and healthcare operations but I will not be denied services if I refuse to consent to disclosure for any other purpose. I consent to the disclosure of Part 2-protected SUD Program information as designated in this consent. I understand I have a right to receive a copy of this consent with the requested records.

 X _____ Date _____
Signature of Patient or Personal Representative

 X _____ Date Revoked: _____ Staff Initials: _____
Relationship / Authority to sign if not patient

PROHIBITION ON RE-DISCLOSURE: 42 CFR Part 2 prohibits unauthorized use or disclosure of these records.
Southwest General Medical Records Dept. • 18697 Bagley Road • Middleburg Heights, Ohio 44130

