



## **Consent for Treatment and Uses and Disclosures of Substance Use Disorder Treatment Information, 42 CFR Part 2**

1. **PATIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

I understand that my substance use disorder treatment records are protected under federal law, including 42 CFR Part 2 and HIPAA, and any applicable state laws. My treatment records can only be used or disclosed with my written consent, except as permitted by 42 CFR Part 2, HIPAA, and applicable state law.

**I understand that I have the right not to sign this consent form.** If I do not sign up, the consequences will be that I will not be able to receive treatment for or related to substance use, including being referred to substance use treatment centers.

2. **CONSENT FOR TREATMENT:** By signing below, I consent to substance use disorder treatment and any other treatment as applicable under 42 CFR Part 2.

3. **AUTHORIZATION:**

a. **I authorize the following person or types of people to use and disclose my records:**

☐ Duffy Health Center staff

b. **I authorize the following person or types of people to receive my records:**

☐ All treating providers, health plans, third-party payers, pharmacy, Duffy staff, and contractors as needed for treatment, payment, and operations, as appropriate.

☐ Only to people or types of people specified below:

c. **RECORDS TO BE USED AND DISCLOSED.** I authorize all future disclosures necessary to facilitate and coordinate care.



d. **PURPOSE.** I authorize uses and disclosures for the following purposes only:

☐ **LEGAL PROCEEDINGS.** I agree to the use and disclosure of my substance use disorder treatment records to be used in the criminal, civil, legislative, or administrative proceeding identified below. **If this box is checked, no other purposes may be listed above.**

4. **EFFECT.** I understand that if HIPAA covered entities and business associates receive these records for treatment, payment, and health care operations purposes, the records may be redisclosed in accordance with HIPAA, except for uses or disclosures for civil, criminal, administrative, or legislative proceedings against me.

5. **TIME PERIOD.** Unless I revoke my consent, this consent will take effect immediately and expire at the end of treatment.

I have the right to revoke this consent in writing at any time, except to the extent that action has been taken in reliance upon it. I understand that I may revoke consent by requesting revocation. I understand that unless indicated this consent will not expire unless revoked.

I have been offered a copy of this form. It has been explained to me in a language I understand. I acknowledge that there is a potential for the records used or disclosed pursuant to this consent to be subject to redisclosure by the recipient and no longer protected by Part 2.

**Signature of patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of other authorized person:** \_\_\_\_\_

**Name of person signing, if other than patient:** \_\_\_\_\_

**Authority of person signing (42 CFR §§ 2.14, 2.15):** \_\_\_\_\_

**Date:** \_\_\_\_\_

NOTE: Electronic signatures are permitted to the extent that they are not prohibited by any applicable law.

42 CFR PART 2 PROHIBITS UNAUTHORIZED USE OR DISCLOSURE OF THESE RECORDS.