

FORM 1
SAMPLE CONSENT TO INDIVIDUAL RECIPIENT
42 CFR Part 2 and HIPAA

REMEMBER: Information disclosed pursuant to patient consent must be accompanied by the notice prohibiting redisclosure.

I, _____,
[patient's name]

authorize _____
[name or general designation of individual or entity making the disclosure]

to disclose _____
[describe how much and what kind of information may be disclosed, including an explicit description of what substance use disorder information may be disclosed; as limited as possible]

to _____
[name of individual(s) who will receive the information]

for the purpose of _____
[describe the purpose of the disclosure; as specific as possible]

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and 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. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

[describe date, event, or condition upon which consent will expire, which must be no longer than reasonably necessary to serve the purpose of this consent]

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

Dated: _____

Signature of Patient

Signature of person signing form if not patient

Describe authority to sign on behalf of patient _____

FORM 2
SAMPLE CONSENT TO TREATING PROVIDER ENTITY RECIPIENT
42 CFR Part 2 and HIPAA

REMEMBER: Information disclosed pursuant to patient consent must be accompanied by the notice prohibiting redisclosure.

A “treating provider relationship” exists when a patient receives, agrees to receive, or is legally required to receive diagnosis, evaluation, treatment, or consultation, for any condition, from an individual or entity who undertakes or agrees to undertake that diagnosis, evaluation, treatment, or consultation. An in-person encounter is not required for a treating provider relationship to exist.

This consent form is for use when a patient wishes to authorize the disclosure of their substance use disorder information to an individual or entity with which the patient has a treating provider relationship.

I, _____,
[patient’s name]

authorize _____
[name or general designation of individual or entity making the disclosure]

to disclose _____
[describe how much and what kind of information may be disclosed, including an explicit description of what substance use disorder information may be disclosed; as limited as possible]

to _____
[name of recipient entity, which has a treating provider relationship with the patient]

for the purpose of _____
[describe the purpose of the disclosure; as specific as possible]

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and 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. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

[describe date, event, or condition upon which consent will expire, which must be no longer than reasonably necessary to serve the purpose of this consent]

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

Dated: _____

Signature of Patient

Signature of person signing form if not patient

Describe authority to sign on behalf of patient _____

Dated: _____

Signature of Patient

Signature of person signing form if not patient

Describe authority to sign on behalf of patient _____

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

Dated: _____

Signature of Patient

Signature of person signing form if not patient

Describe authority to sign on behalf of patient _____
