Focus:PHI

SAMPLE CONSENT: HEALTH INFORMATION EXCHANGE

AUTHORIZING DISCLOSURE OF CONFIDENTIAL SUD PATIENT RECORDS

REMEMBER: Records 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 *explicit description* of any substance use disorder information to be disclosed; should be as limited as possible]

to _____, and the following participants:
[name of Health Information Exchange]

_____;
[name of individual or entity participant(s) in Health Information Exchange listed above; can list multiple participants]

☐ *OPTIONAL:* By checking this box, I also authorize disclosure to all my current and future treating providers who participate in the Health Information Exchange. I understand that I have a right to receive a list of all such disclosures from the Health Information Exchange.

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

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of 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. Parts 160 and 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:

_____.
[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 may be denied services if I refuse to consent to disclosure for purposes of treatment, payment, or healthcare 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:

Date revoked: _____ **Staff initials:**

Created August 2020. Resources, training, technical assistance, and any other information provided through the CoE-PHI do not constitute legal advice.

CAI LAC LEGAL ACTION CENTER

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