



**SAMPLE CONSENT TO: ENTITY WITH A TREATING PROVIDER RELATIONSHIP*
AUTHORIZING DISCLOSURE OF CONFIDENTIAL SUD PATIENT RECORDS**

REMEMBER: Records 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.

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 any substance use disorder information to be disclosed; should be as limited as possible]

to _____
[name of entity with a treating provider relationship who will receive the information]

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: