Pathways[SM]

Version 1.0

CONSENT FOR DISCLOSURE OF SUD RECORDS
42 CFR Part 2

PLEASE NOTE: *Information disclosed pursuant to CONSUMER consent must be accompanied by the notice prohibiting re-disclosure*

I, ____ ,
[Consumer's name and DOB]

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: (select **ONE** of the following options):

1. ☐ Individual Recipient: ____
[name/address of individual(s) who will receive the information]

2. ☐ 3rd Party Payor Recipient: ____
[name/address of third-party payor]

3. ☐ Treating Provider**: ____
[name/address of entity with treating provider relationship with consumer)

** 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.

4. ☐ Non-Treating Provider: ____
[name/address of entity which does NOT have a treating provider relationship with the consumer]

____
[names of individual participants in the entity listed above]

and ____
*[names of entity participants in the entity listed above, **only if the entity participants have a treating provider relationship with the consumer**]*

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

*I understand that if a general designation is used in the "Authorize/To Whom" section of this Consent, I have the right to receive a list of entities to which my Part 2 substance use disorder information has been disclosed.

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 Consumer

____
*Signature of person signing form if not Consumer**

____
Witness Signature/Relationship

**Describe authority to sign on behalf of Consumer* ____
____

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