



Authorization to Disclose Confidential Substance Use Disorder Health Information

This form asks for your permission to have your substance use treatment providers share information with other members of your health care team.

I. PATIENT/MEMBER INFORMATION: (Name and information of person whose substance use disorder health information is being disclosed)

Name: _____

Address: _____

Member ID#: _____ Date of Birth: _____

II. IDENTITY OF ENTITIES WHO MAY SHARE SUBSTANCE USE DISORDER HEALTH INFORMATION

(Insert name of Treatment Program/Provider/Facility)

may communicate with and disclose my substance use disorder health information to the following entities (select one or more of the below options):

_____; and/or
(Insert name of an entity with provider relationship with the patient)

The CountyCare Health Plan, including any third party administrator managing health benefits on behalf of CountyCare and/or any contractor, subcontractor or legal representative providing payment or health care operation activities on behalf of CountyCare; and/or:

MHN, including its MHNConnect health information exchange and the MHNConnect participating providers who provide or have provided health care services to me. Where I allow MHN (via MHNConnect and its participating providers) to access my substance use treatment information, MHN will deliver to me, upon request, a list of the providers that have received my information via MHNConnect within the last two years.

III. PURPOSE OF USE OR DISCLOSURE OF SUBSTANCE USE DISORDER HEALTH INFORMATION

I am authorizing this use and/or disclosure or re-disclosure of my substance use disorder health information to allow my providers to communicate my diagnosis and treatment information with each other and to my health plan and its third party administrators **for the purposes of coordinating my care and treatment**. Any information disclosed should be limited to the amount information necessary to carry out the above stated purpose.

IV. DESCRIPTION OF SUBSTANCE USE DISORDER HEALTH INFORMATION TO BE USED OR DISCLOSED

With my permission, the entities listed above (see Section II) may share my substance use disorder health information, including information about substance use disorder diagnosis, treatment, prognosis or referral. The information shared may relate to my diagnosis, care or treatment, including medical and pharmacy records, information related to my application for, enrollment in, and eligibility for health care service and any information about my health plan benefits and claims related to my health care.

As applicable, additional information necessary to coordinate in my health care and treatment may also be released, such as:

(Check box and insert description of other information as applicable)

V. EXPIRATION

This Authorization will expire *(select one)*:

One (1) year from my disenrollment from the CountyCare Health Plan

Ten years from the last date on which I received services from an entity listed in this Authorization or

Other: _____
(Insert date or event)

If I don't select one of the boxes above, this authorization will expire in ten years from the last date on which I received services from an entity listed in this Authorization.

VI. IMPORTANT INFORMATION

I have read and understand the following statements about my rights:

- I understand that my substance use disorder health information records are protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164.
- I may revoke this authorization at any time prior to its expiration date by notifying my provider or CountyCare in writing, but the revocation will not have any effect on any actions my provider, CountyCare, or its affiliates took before it received the revocation.
- I understand that entities that receive my substance use disorder health information under this Authorization cannot re-disclose this information except with my Authorization. I understand that the persons and entities I have identified in Section II are authorized to disclose and re-disclose the information identified in Section II to one another.
- I have a right to receive a copy of this Authorization. A copy of this Authorization is as valid as the original.
- I understand that I am not required to sign this form to receive my treatment or my health care benefits (enrollment, treatment, or payment).

VII. SIGNATURE

The patient/member listed above must sign this form to authorize their provider to release his/her substance use disorder health information. If the patient/member cannot sign, only the patient/member's legal representative may sign. If you are the patient/member's legal representative, describe this relationship below and send us copies of those forms (such as power of attorney or order of guardianship). For patients/members 12 years or older, a patient/member's legal representative is not required to sign and the patient/member must sign on their own.

Signature of Patient	Date

Signature of Representative	Date

Description of Relationship to Patient/Member

OPTION TO DECLINE

(Check box if applicable) At this time, **I decline to authorize** my providers to use and/or disclose or re-disclose my substance use disorder health information to communicate my diagnosis and treatment information as described above.

PROHIBITION ON REDISCLOSURE OF CONFIDENTIAL INFORMATION

42 CFR part 2 prohibits unauthorized disclosure of these records.

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FOR ADMINISTRATIVE USE ONLY	
The patient/member has reviewed this form and been given the option to consent to the release of his/her substance use disorder health information. At this time, the patient/member does not authorize the release of this information.	
Signature of Provider Staff Representative	Date