Patient Consent for Disclosure of Part 2 Records

CarePartners of Connecticut MEDICARE ADVANTAGE

Your consent allows a Part 2 program (*or other Person*) to disclose Part 2 records for purposes of **treatment, payment,** and **health care operations.** A Part 2 program is a program that is federally assisted and provides substance use disorder (SUD) diagnosis, treatment, or referral for treatment.

A. PATIENT INFORMATION

Patient's Name:

Health Plan ID# : Date of Birth:

Address:

City/State/Zip:

Phone: Email:

B. PERSON(S) PERMITTED TO MAKE DISCLOSURES

Please fill in the name of the Part 2 program (*i.e., provider furnishing treatment to you*)

C. RECIPIENT OF AND PURPOSE FOR DISCLOSURE

The provider may use information about me and disclose it to my treating health care providers, my health plans (*health insurers*), other third-party payers, and their business associates (*vendors*) for the provider's treatment, payment, and health care operations. The information may then be redisclosed as permitted by the HIPAA Privacy Rule, including (*but not limited to*) for treatment, payment, and health care operations, **except that:**

The information cannot be used or disclosed for civil, criminal, administrative, or legislative proceedings against me.

D. INFORMATION THAT MAY BE DISCLOSED

All information necessary to process my claims and coordinate my care may be disclosed. This may include (*among other information*) diagnoses (*names of illnesses or conditions*), procedures (*type of treatments*), my prescriptions, dates of treatment, and names of health care practitioners or other providers who treat me.

E. EXPIRATION OR REVOCATION OF CONSENT (*Please check one.*)

☐ My consent **will not expire.** ☐ My consent **will expire.** Date of expiration:

You may revoke this consent at any time by contacting the Provider at the address provided below. Your revocation will not be effective, however, to the extent that the Provider or others have already acted in reliance on the consent.

F. IMPORTANT INFORMATION ABOUT THIS CONSENT

Although the records described above will continue to be protected by the HIPAA Privacy Rule, once the Provider discloses records as permitted by this consent, the records will no longer be protected by the Confidentiality of Substance Use Disorder Patient Records Rule (Part 2).

If you do not sign this consent, however, the Provider may not provide treatment to you and your health plan (*health insurer*) may not pay claims for your treatment because it will not know whether it is permitted to use or disclose information for payment and other health plan purposes.

G. PATIENT SIGNATURE AND DATE

I have read the contents of this form. I agree to allow the disclosures of my information as described above.

Signature of Patient:

Signature of person authorized to provide consent under 42 C.F.R. §§ 2.14 or 2.15, if applicable:

Relationship of person authorized to provide consent, if applicable:

Today's Date:

To revoke this consent, you may contact the Part 2 program (*Part 2 provider or other person obtaining consent*) at the address, phone number, or email listed in the box below:

CLEAR FORM