Consent for the Release of Information under 42 C.F.R. Part 2 Confidentiality of Substance Use Disorder Patient Records

I, _____, _____,
PATIENT NAME — DATE OF BIRTH (MM/DD/YYYY)

hereby authorize BrightView, LLC to release/disclose the information below:

NAME OF PERSON/ORGANIZATION/PROVIDER WHO IS RECEIVING YOUR RECORDS (If this is for a court, department, or doctor's office, put the name of that group or department, not the name of an individual):

_____

Contact information (Phone number, fax, email. If unknown, add N/A.):

_____

INFORMATION TO BE DISCLOSED: I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), mental health and substance use. I authorize the release or disclose of the records below (select only one of the two options):

Option 1:

☐ All records (i.e. your full medical record, including but not limited to the categories below)

Or

Option 2: Only the following specific types of records (check each category that applies):

☐ Appointments
☐ Attendance
☐ Behavioral Health Assessments
☐ Behavioral Health Progress Notes
☐ Diagnosis
☐ Discharge Summary
☐ Insurance Information
☐ Medical Progress Notes
☐ Medical Psychiatric Notes
☐ Medication(s)/Dosing
☐ Referral Information
☐ Treatment Plans
☐ Toxicology Results
☐ Lab Results (excludes toxicology results)
☐ Other: _____

DATE OF INFORMATION TO BE DISCLOSED (SELECT ONLY ONE OF THE TWO OPTIONS):

Option 1:

☐ All dates of service

Or

Option 2 (Note: if left blank, end date will be one year from date of signature):

☐ Specific dates, start: _____ (MM/DD/YYYY) end: _____ (MM/DD/YYYY)

PURPOSE OF DISCLOSURE (SELECT ALL THAT APPLY):

☐ Continuity of Care
☐ Coordinating Treatment
☐ Legal
☐ Payment/Benefits
☐ Other: _____

By signing this document, I understand that my substance use disorder patient records are protected under federal regulations 42 C.F.R. Part 2 Confidentiality of Substance Use Disorder Patient Records and cannot be disclosed without my written consent. I do not need to sign this form to obtain treatment. **This consent will terminate in one year from the date of signature or 90 days after discharge, whichever comes first, unless otherwise specified here**:

I understand that generally BrightView may not condition my treatment on whether I sign a consent form, but in certain limited circumstances, I may be denied treatment if I do not sign a consent form. I may revoke this consent at any time in person, by email, or verbally by calling BrightView, but I understand that the revocation will not be effective retroactively for disclosures that have already occurred.

SIGNATURE OF PATIENT

PATIENT'S SIGNATURE

DATE (MM/DD/YYYY)

PRINT NAME

If applicable, **SIGNATURE OF PERSONAL REPRESENTATIVE;** required only if patient is under a legal guardianship

PERSONAL REPRESENTATIVE'S SIGNATURE

DATE (MM/DD/YYYY)

PRINT NAME

LEGAL AUTHORITY

Notice of Federal Requirements Regarding the Confidentiality of Substance Use Disorder Patient Information

The confidentiality of substance use disorder patient records maintained by this program is protected by federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser unless:

1. The patient consents in writing; or
2. The disclosure is allowed by a court order accompanied by a subpoena; or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation; or
4. The patient commits or threatens to commit a crime either at the program or against any person who works for the program.

Violation of federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

The releases of information will remain active and valid for one year from the date of signature OR until 90 days after discharge (whichever comes first) OR until a specific date, event, or condition as listed on the form. There are two ways to revoke a release of information: Come in to the BrightView facility where you were scheduled to receive treatment and sign the revocation, or fax in a written statement with your name, signature, date and release(s) you would like to be revoked.

(See U.S.C. §290dd-2 for federal law and 42 C.F.R. Part 2 for federal regulations governing Confidentiality of Substance Use Disorder Patient Records.)

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