

**PATIENT CONSENT TO RELEASE INFORMATION PROTECTED BY PART 2**

Some of your records related to substance use disorder diagnosis and treatment are protected from disclosure by the Federal Regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 CFR Part 2, also known as "Part 2". These records may only be disclosed by your Part 2 Provider with your written consent unless otherwise provided for by Part 2.

By signing below, you consent to the disclosure of your substance use disorder records to the party you name below. No redisclosure is permitted without your consent or as otherwise permitted by Part 2.

You may revoke your consent at any time except to the extent that action has been taken in reliance on it.

You may be denied services if you refuse to consent to disclosure for the purposes of treatment or payment. You will not be denied services if you refuse to consent to disclosure for other purposes.

<b>Patient Name OR Label:</b> _____ <b>Birthdate:</b> _____ <b>Medical record:</b> _____
<b>You consent to disclosure of your information by this individual or organization (choose one):</b> <input type="checkbox"/> Community-University Health Care Center. <input type="checkbox"/> _____
<b>Your information should be disclosed to (choose one):</b> <input type="checkbox"/> Community-University Health Care Center. <input type="checkbox"/> _____
<b>The purpose of this disclosure is (choose one):</b> <input type="checkbox"/> Treatment. <input type="checkbox"/> Payment. <input type="checkbox"/> Other
<b>Indicate the information you wish to have disclosed. You may choose 'all my substance use disorder information', or select from the other options below:</b> <input type="checkbox"/> All my substance use disorder information, OR select from the options below: <input type="checkbox"/> Medical clinical notes. <input type="checkbox"/> Psychiatric notes. <input type="checkbox"/> Lab tests. <input type="checkbox"/> Laboratory/Pathology notes. <input type="checkbox"/> Therapy notes. <input type="checkbox"/> Medication list. <input type="checkbox"/> Immunizations. <input type="checkbox"/> Diagnostic assessments. <input type="checkbox"/> Claims data. <input type="checkbox"/> Other: _____
<b>This authorization will expire:</b> <input type="checkbox"/> In one year. <input type="checkbox"/> On this date: _____ <input type="checkbox"/> On this condition or event: _____
<b>Signature:</b> _____ Signature of Patient/Authorized Person      Authorized Person's authority to sign      Date

<b>FOR USE OF CUHCC STAFF ONLY</b>
<input type="checkbox"/> This consent is to release Part 2 information to CUHCC. No additional HIPAA Authorization is necessary. <input type="checkbox"/> This consent is to release Part 2 information outside of CUHCC. The patient must complete both this form and a HIPAA Authorization (ROI) prior to disclosure of the patient's information. <input type="checkbox"/> The patient refused to sign the consent. Part 2 information may not be disclosed beyond CUHCC's Part 2 Providers or as otherwise provided for by an existing Part 2 consent.