UNIVERSITY OF MINNESOTA
Community-University Health Care Center 2001 Bloomington Ave S Phone: 612-301-3433
www.cuhcc.umn.edu Minneapolis, MN 55404 -3089 Fax: 612-426-4710

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.

Patient Name OR Label: _____

Birthdate: _____

Medical record: _____

You consent to disclosure of your information by this individual or organization (choose one):

☐ Community-University Health Care Center.

☐ _____

Your information should be disclosed to (choose all that apply):

☐ Community-University Health Care Center Providers.

☐ **Fairview, HCMC, UMMC, OCHIN (OCHA)**_____

☐ OTHERS _____

The purpose of this disclosure is (choose one):

☐ Treatment. ☐ Payment. ☐ Other: _____

Indicate the information you wish to have disclosed. You may choose 'all my substance use disorder information', or select from the other options below:

☐ All my substance use disorder information, OR select from the options below:

☐ Medical clinical notes. ☐ Psychiatric notes. ☐ Lab tests.

☐ Laboratory/Pathology notes. ☐ Therapy notes. ☐ Medication list.

☐ Immunizations. ☐ Diagnostic assessments. ☐ Claims data.

☐ Other: _____

This authorization will expire:

☐ In one year.

☐ On this date: _____

☐ On this condition or event: _____

Signature:

Signature of Patient/Authorized Person	Authorized Person's authority to sign	Date
_____	_____	_____

FOR USE OF CUHCC STAFF ONLY

☐ This consent is to release Part 2 information to CUHCC. No additional HIPAA Authorization is necessary.

☐ 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.

☐ 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.