**AUTHORIZING DISCLOSURE OF CONFIDENTIAL SUBSTANCE USE DISORDER PATIENT RECORDS**

***REMEMBER: Records disclosed pursuant to patient consent must be accompanied by the notice prohibiting redisclosure.***

*A "treating provider relationship" exists when a patient receives, agrees to receive, or is legally required to receive diagnosis, evaluation, treatment, or consultation, for any condition, from an individual or entity who undertakes or agrees to undertake that diagnosis, evaluation, treatment, or consultation. An in-person encounter is not required for a treating provider relationship to exist.

I, _____,
[patient's name]

authorize_____
[name or general designation of individual or entity making the disclosure]

to disclose name, telephone number, gender, date of birth, pregnancy status, last four digits of social security number, waitlist ID number, insurance, assessment information, and most recent ASAM including recommended level of care_____

to _____
[name of entity with a *treating provider relationship who will receive the information]

for the purpose of aiding in admission to substance use disorder treatment through placement on a waitlist.

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

60 days after the date this consent is signed.

I have been provided a copy of this form.

Dated: _____ _____

Signature of Patient

_____

Signature of person signing form if not patient

Describe authority to sign on behalf of patient _____

_____

**By signing below, I am revoking this Consent for the Release of Substance Use Disorder Treatment Records.**

**Patient Revocation: _____ Date: _____**