Consent to Share Behavioral Health and Substance Use Treatment Information

Legal Last Name of Patient:	First Name:	MI:	Date of Birth:
Other Names Used by Patient:			Individual ID number (Medical ID, last 4 digits of SSN):
Patient Address:			

I, the above patient, or the patient's legal representative if applicable, consent to the disclosure of behavioral health and substance use treatment information by the provider(s) identified in Section A, to the entity identified in Section B.

I understand that this information will be disclosed using secure electronic health information exchange services provided by the Reliance eHealth Collaborative. This information will be disclosed for the following purposes:

- To provide me with medical care and related services ("treatment"). The information disclosed may include all information I have consented to disclose, if it is necessary for such treatment.
- To manage my health care, including assisting me in obtaining appropriate medical care, improving the quality of services provided to me, coordinating multiple health care services provided to me if applicable, or supporting me in following a plan of medical care. The information disclosed may include the fact of admission to and dates of care, diagnosis, medications, and any plan of care.
- To evaluate and improve the quality of medical care provided to me and other patients. The information disclosed may include the fact of admission to and dates of care, diagnosis, medications, and any plan of care.

A. Organization(s) Authorized to Disclose	B. Organization Authorized to Receive
Please specify the name of the substance use disorder programs or behavioral health facilities that have provided you with care and are authorized to disclose your information. 1. 2. 3. 4. 5.	Please specify the entity that may receive your information pursuant to this designation. If you wish to consent to disclosure of your information to a health plan, you must identify the health plan specifically. I hereby consent to disclosure of my information to authorized health care providers in the following entity: ☐ [enter Name of Organization here]

C. I consent to the disclosure of all behavioral health and substance use disorder treatment information (e.g. admission and dates of care, diagnosis, medications, and any plan of care) to the health care entity identified in Section B, if necessary:

☐ For purposes of treatment

☐ For purposes of care management

☐ For purposes of quality improvement

Disclaimer: this template form is provided as an example for educational purposes only, and is not provided as legal advice or an official recommendation. No consent form should be used or adopted without consultation with a provider's/organization's own legal counsel.

D. **Expiration Date** (default is one (1) year from date of signing unless otherwise specified):_____

E. I understand that by signing this form I acknowledge that I understand that:

1. I understand that my treatment or payment for my health care may not be conditioned on my execution of this consent. However, I further understand that if I do not consent, the failure to provide information may cause incorrect or inappropriate diagnosis and treatment decisions, and interfere with or prevent payment for my health care by a health plan.
2. I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2 and cannot be disclosed without my written consent unless otherwise provided for by these regulations.
3. Behavioral health information may not be subject to the Substance Abuse Disorder regulations, and may be subject to redisclosure and no longer protected under Federal or State law.
4. I can cancel or revoke this authorization at any time, but that this revocation will not apply to any information already disclosed or released. I must notify entities listed on this form if I choose to withdraw my consent in the future.
5. I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.
6. Expiration date: This authorization is valid for one year from the date of signing unless otherwise specified above.
7. I am signing this authorization of my own free and I was given the opportunity to ask questions about this form and what it does.

Signature of Patient or Patient's Legal Representative:	Phone Number:	Date:
Print Name of Legal Representative (if applicable):	Relationship to and Authority of Legal Representative to sign on behalf of Patient (if applicable):	