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| **PATIENT INFORMATION** |
|  |
| **Last Name** | **First Name** | **Middle Initial** |
|  |  |  |  |  |
| **Date of Birth** | **Social Security No.**  | **Home Phone** | **Work Phone** | **Extension** |
|  |  |  |  |
| **Street Address** | **City** | **State** | **Zip Code** |
| **I HEREBY AUTHORIZE THAT MY INDIVIDUALLY IDENTIFIABLE** **SUBSTANCE USE DISORDER (SUD) INFORMATION BE RELEASED FROM:** |
| • **BHCS County Staff**• **BHCS SUD Provider Network (collectively SPN)\*** | ([ ] ) Check box and complete below to add a treatment provider outside BHCS/SPN network: |
| **Non-SPN Treatment Provider** | **Phone Number** | **Extension** |
|  |  |  |
| **Street Address City** | **State** | **Zip Code** |
| **I HEREBY AUTHORIZE THAT MY INDIVIDUALLY IDENTIFIABLE** **SUD INFORMATION BE RELEASED TO AND USED BY:** |
|  |  |
| **Name of Emergency Contact #1** | **Phone Number** | **Extension** |
|  |  |  |
| **Street Address City** | **State** | **Zip Code** |
|  |  |  |
|  |  |
| **Name of Emergency Contact #2** | **Phone Number** | **Extension** |
|  |  |  |
| **Street Address City** | **State** | **Zip Code** |

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| I understand that my SUD treatment, diagnosis, and referral; payment; enrollment; case management; care coordination; medication management; and/or eligibility for benefits are conditioned on completing this authorization.  |
| **EXPIRATION:** **This Authorization expires twelve (12) months from last date of SUD services by BHCS and/or SPN.** |
| **Disclosure Purpose Amount and Kind** |
| • Lawful holders of my protected SUD information may contact my emergency contact(s) in the event of an emergency, and thereby disclose that I am a patient being served in this SUD program.  | • Limited to that information which is necessary to  carry out the Disclosure Purpose• I permit lawful holders to re-disclose my protected SUD information subject to this authorization and  42 CFR part 2• Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Signature of Patient**  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Print/Type Name** |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**  |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Signature of Parent or Guardian**  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Print/Type Name** | ([ ] ) Parent \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_([ ] ) Guardian **Date** |
| **REVOCATION AND REQUEST:** I understand that I have a right to revoke this authorization at any time unless action has been taken in response to or in reliance on this authorization. I understand to contact a BHCS Health Information representative in order to revoke the authorization granted to BHCS. I further understand that I should provide a separate revocation to any other person or entity that I have authorized to disclose, receive, or otherwise use my individually identifiably SUD information above in order to revoke the authorization granted to that person or entity. \* SPN includes past, current, and future network providers. A directory of current network providers participating in the SPN is available athttp://www.acbhcs.org/SUD/docs/SUD\_providers\_dirctory.pdf. I understand that I have a right to request a list of entities to which my patient identifying information has been disclosed pursuant to a general designation under this authorization and applicable regulations. I further understand that such a request must be in writing and limited to disclosures made within the past two years. |
| **PROHIBITION ON RE-DISCLOSURE OF PROTECTED SUD INFORMATION:** 42 CFR part 2 prohibits unauthorized disclosure of these records. |
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| **SUD-ROI-EMERGENCY CONTACT - REV 04/18** |