|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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** | |

|  |  |  |  |
| --- | --- | --- | --- |
| 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. | | | |
|  | | | |
| **SUD-ROI-EMERGENCY CONTACT - REV 04/18** | | | |