



Jamestown Healing Clinic Consent for Uses and Disclosures of Substance Use Disorder Treatment Information, 42 CFR Part 2

PATIENT NAME: _____ DOB: _____

I understand that my substance use disorder treatment records are protected under federal law, including 42 CFR Part 2 and HIPAA, and any applicable state laws. My treatment records can only be used or disclosed with my written consent, except as permitted by 42 CFR Part 2, HIPAA, and applicable state law.

I understand that I have the right not to sign this consent form (examples of consequences may be, but are not limited to limitations to coordination of care; billing and insurance issues; legal or mandatory referral compliance; inability to participate in specific programs.) If I do not sign, the consequences may be:

1. AUTHORIZATION.

a. I authorize the following person or types of people to use and disclose my records:

Jamestown Healing Clinic Other (*Full name and contact information*):

b. I authorize the following person or types of people to receive my records:

Name of facility, program, agency or individual. (*Use full legal name of individual or full name of treatment provider, clinic or medical system or organizations.*)

Jamestown Healing Clinic
526 S. 9th Ave, Sequim, WA 98382
Phone: 360-681-7755, Fax: 360-681-5999

Full name and contact information

c. RECORDS TO BE USED AND DISCLOSED. I authorize the following information to be used or disclosed: (*If only sending SUD information, SKIP and leave this section empty and check box below. Otherwise, categories may include medications and dosages, diagnostic information, SUD history or progress notes, treatment plans, discharge summaries.*)

SUD COUNSELING NOTES: I agree to the use and disclosure of my substance use disorder (SUD) counseling notes. A Part 2 program may not require me to check this box as a condition of treatment, payment, enrollment in a health plan, or eligibility for benefits. **If this box is checked, no other information may be listed above.**

Patient ID: _____

d. PURPOSE. I authorize uses and disclosures for the following purpose(s) only:

(If purpose is legal proceedings, skip this section and check box below.)

- For treatment, payment, and healthcare operations for all future uses and disclosures.
- At the request of the patient.

Jamestown Healing Clinic does not engage in fundraising and will not use patient's information for this purpose.

LEGAL PROCEEDINGS. I agree to the use and disclosure of my substance use disorder treatment records to be used in the criminal, civil, legislative, or administrative proceeding identified below. **If this box is checked, no other purposes may be listed above.** *(Enter Case No./Investigation No. (if known))*

2. EFFECT. I understand that if HIPAA covered entities and business associates receive these records for treatment, payment, and health care operations purposes, the records may be redisclosed in accordance with HIPAA, except for uses or disclosures for civil, criminal, administrative, or legislative proceedings against me.

3. TIME PERIOD. Unless I revoke my consent, this consent will take effect immediately and expire:

Date, event or condition upon consent will expire if other than end of treatment. Choose specific date, condition, OR choose End of Treatment below. *(Consider one year from date of signature or more specifically 30 or 90 days from event.)*

End of treatment, if purpose is for treatment, payment or health care operations. Choose end of treatment OR choose specific date, event, condition as above. *(End of treatment defined as 30 days after discharge from Jamestown Healing Clinic).*

I have the right to revoke this consent in writing at any time, except to the extent that action has been taken in reliance upon it. Unless I revoke my consent earlier, this consent will expire at the end of treatment.

I understand that in order to revoke this consent, I will speak to my counselor and/or a patient care coordinator to request update of records immediately.

I have been offered a copy of this form. It has been explained to me in a language I understand. I acknowledge that there is a potential for the records used or disclosed pursuant to this consent to be subject to redisclosure by the recipient and no longer protected by Part 2.

Date Revoked: _____

Staff Initials: _____

NOTE: Electronic signatures are permitted to the extent that they are not prohibited by any applicable law.
42 CFR PART 2 PROHIBITS UNAUTHORIZED USE OR DISCLOSURE OF THESE RECORDS.

Patient ID: _____



Notice of Privacy Practices of Jamestown Healing Clinic

Patient Name:

DOB:

Today's Date:

FEDERAL LAW PROTECTS THE CONFIDENTIALITY OF SUBSTANCE USE DISORDER PATIENT RECORDS.

This notice described:

- How health information about you may be used and disclosed.
- Your rights with respect to your health information.
- How to file a complaint concerning a violation of the privacy or security of your health information or of your rights concerning your information.

YOU HAVE A RIGHT TO A COPY OF THIS NOTICE (IN PAPER FORM) AND TO DISCUSS IT WITH YOUR JHC COUNSELOR, JHC SUPERVISOR, OR JHC ADMINISTRATOR AT 360-681-7755 OR info@jamestownhealingclinic.org IF YOU HAVE ANY QUESTIONS.

I. Uses and disclosures.

- JHC may use or disclose records without the patient's written request under the following circumstances:**
 - Internal Communications:** share information internally between program personnel who have a "need to know" the information in connection with their duties in providing your diagnosis, treatment, or referral. This includes clinical, billing, and administrative staff within our program.
 - Medical Emergencies:** disclose information to medical personnel to treat a condition that poses an immediate threat to health and which requires immediate medical intervention.
 - Child Abuse and Neglect:** as mandatory reporters, we are required by Federal law to report any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.
 - Crimes on Program Premises or Against Program Personnel:** disclose limited information to law enforcement to report a crime (or threat of a crime) committed by a patient at our program or against our staff. This is limited to the circumstances of the incident and basic identifying information.
 - Audit and Evaluation:** disclose records to authorized government agencies or private entities that provide financial assistance or oversight to our program. These auditors must agree to protect your information and cannot use it to investigate you.
- JHC will obtain written consent for the following situations:**
 - Coordination of Care:** facilitating all medical treatment providers, (SUD, medical and behavioral)
 - Billing and Insurance:** prior authorization for services, insurance claims and denials, other billing services.
 - Legal or Mandatory Referrals:** drug court, probation or parole, child welfare.
 - Participation in Specific Programs:** specifically for specialized, integrated SUD or Behavioral Health (BH) programs, like inpatient or withdrawal management services.
- A patient may provide a single consent for all future uses or disclosures for treatment, payment, and health care operations purposes.

PATIENT ID: _____

- d. Jamestown Healing Clinic will only use and disclose your protected information as described in this notice, or with your written consent.
- e. You may revoke your consent at any time, except to the extent Jamestown Healing Clinic has acted in reliance upon it.

You may revoke consent by submitting a request in writing to Jamestown Healing Clinic administration at 360-681-7755/ info@jamestownhealingclinic.org or you may request reasonable accommodation for an alternative revocation process by contacting JHC Healing Clinic administration at 360-681-7755 or info@jamestownhealingclinic.org.

- f. If you were mandated to treatment through the criminal legal system (including drug court, probation, or parole) and you sign a consent authorizing disclosures to elements of the criminal legal system such as the court, probation officers, parole officers, prosecutors, or other law enforcement, your right to revoke consent may be more limited and should be clearly explained on the consent you sign.
- g. Records, or testimony relating the content of such records, shall not be used or disclosed in any civil, administrative, criminal, or legislative proceedings against you unless based on your specific written consent or a court order. Records shall only be used or disclosed based on a court order after notice and an opportunity to hear is provided to you (the patient) and/or the holder of the record, where required by 42 USC § 290dd-2 and 42 CFR Part 2. A court order authorizing use or disclosure must be accompanied by a subpoena or other similar legal mandate compelling disclosure before the record is used or disclosed.

II. Your rights:

- a. You have the right to request restrictions of disclosures, for purposes of treatment, payment, and healthcare operations, including when you have previously provided written consent.
 - i. Schedule an appointment to meet with your primary counselor to discuss which restrictions you are requesting. They will review the consequences that may be associated with changes, including, but not limited to:
 1. Limitations to coordination of care
 2. Billing and insurance issues
 3. Legal or mandatory referral compliance
 4. Participation in specific program
- b. You have the right to request and obtain restrictions of disclosures to your health plan for those services for which you have paid in full.
 - i. Discuss your request with a patient care coordinator or administrator, at which time you will need to complete and sign a form with the following:
 - ii. You have the right to request that we restrict the disclosure of your records to your health plan if you choose to pay for a service **entirely out-of-pocket**. If you pay in full for a service at the time of treatment, we **must** honor your request to not share that specific information with your health insurance company.
- c. You have the right to request an accounting of disclosures of electronic records under this part for the past three years, including information about who received your protected records, the date of the disclosure, and a brief description of the information that was disclosed. You may submit your request to JHC Administrator at 360-681-7755 or info@jamestownhealingclinic.org.
- d. You have the right to obtain a copy of this notice form upon request.
- e. You have the right to discuss this notice with the contact person or office designated at the end of this notice.
- f. Jamestown Healing Clinic does not engage in fundraising and will not use patient's information for this purpose

III. Jamestown Healing Clinic's duties:

- a. Jamestown Healing Clinic is required by law to maintain the privacy of records, to provide patients with notice of its legal duties and privacy practices with respect to records, and to notify affected patients following a breach of unsecured records.
- b. Jamestown Healing Clinic is required to abide by the terms of the notice currently in effect.
- c. Jamestown Healing Clinic reserves the right to change the terms of its notice and to make the new notice provisions effective for records that it maintains.
 - i. Jamestown Healing Clinic will notify all patients in writing of any changes of terms. This will include a process for all patients to have the opportunity to meet individually with a counselor or administrator to review and sign new notice.

IV. Complaints:

- a. If you believe your privacy rights have been violated, you have the right to file a complaint with the Secretary of the U.S. Department of Health and Human Services and Jamestown Healing Clinic. You may do so by contacting the HHS Office for Civil Rights or accessing <https://www.hhs.gov/hipaa/filing-a-complaint/index.html>. A patient is not required to report an alleged violation either to the Secretary or part 2 program but may report to either or both.
- b. To file a complaint with Jamestown Healing Clinic you may request a feedback form or a formal grievance form from your counselor or the patient care coordinators at the front office. You may also submit your request to JHC Administrator at 360-681-7755 or info@jamestownhealingclinic.org
- c. Jamestown Healing Clinic will not retaliate against you for filing a complaint.

FOR ADDITIONAL INFORMATION, CONTACT:

Administrator

Jamestown Healing Clinic

360-683-7755

info@jamestownhealingclinic.org

EFFECTIVE DATE:

PATIENT ID: _____