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

Patient Name: (Please print) _____ Date of Birth: _____

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*:*

Inability or limitations to care coordination.
Challenges with insurance billing.
Other:

1. AUTHORIZATION

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

☐ Jamestown Healing Clinic

526 S. 9th Ave, Sequim, WA 98382
Ph: 360-681-7755
Fx: 360-681-5999

☐ 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.)*

☐

Full name and contact information

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

c. RECORDS TO BE USED AND DISCLOSED

☐ I authorize the following information to be used or disclosed: (C*ategories may include medications and dosages, diagnostic information, SUD history or progress notes, treatment plans, discharge summaries, SUD medical notes)*

☐ **SUD COUNSELING NOTES: If this box is checked, no other information may be listed above.**

Per 42 CFR Part 2: *Substance use disorder (SUD) counseling notes means notes recorded (in any medium) by a part 2 program provider who is a SUD or mental health professional documenting or analyzing the contents of conversation during a private SUD counseling session or a group, joint, or family SUD counseling session and that are separated from the rest of the patient's SUD and medical record. SUD counseling notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.*

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.

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./Parole Officer/ Court Information (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 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.

Signature of patient: _____ Date: _____

Signature of other authorized person: _____

Name of person signing, if other than the patient: _____

Authority of person signing (42 CFR §§ 2.14, 2.15): _____ Date: _____

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.

Date Revoked: _____ Staff Initials: _____