AUTHORIZATION FOR RELEASE OF CONFIDENTIAL SUBSTANCE USE DISORDER ("SUD") PATIENT RECORDS BY PRIMECARE MEDICAL, INC.

Patient Name:_____ SSN:_____
Address:_____ Date of Birth: _____
_____

I hereby authorize **PrimeCare Medical, Inc. d/b/a PCM Correctional Health Care, Inc.** at the _____ (facility) to disclose the following information relevant to my treatment and case management plan (*initial*):

____ Course and results of treatment
____ Attendance in treatment
____ Substance use history
____ Diagnostic summary and diagnosis
____ Medical history / treatment
____ Drug / Alcohol test results
____ Biopsychosocial assessments
____ Evaluations and recommendations
____ Other: _____

____ Treatment plans
____ Disciplinary records
____ Legal history
____ Discharge summary
____ Social / Family history
____ Eligibility
____ Psychiatric Evaluation / Treatment
____ Verbal Exchange of information

To (*select one*):

_____ Individual(s): _____

_____ Entity **with** a treating provider relationship* (name and address of entity) _____
_____

_____ Entity **without** a treating provider relationship: To the following participants of
_____
[name and address of receiving entity]:
_____and/or
[name of individual participant(s) recipient in entity].
_____
[name of entity participant(s) in recipient entity, ***but only if the entity participant has a treating provider relationship*** with the patient].

Purpose(s) of disclosure [describe, be as specific as possible]: _____
_____
_____

* A "treating provider relationship" exists when a patient receives, agrees to receive, or is legally required to receive diagnosis, evaluation, treatment, or consultation, for any condition, from an individual or entity who undertakes or agrees to undertake that diagnosis, evaluation, treatment, or consultation. An in-person encounter is not required for a treating provider relationship to exist.

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically one (1) year from the date that I sign it, or 30 days post-termination of services. I also understand that my revocation of this Authorization will not impact any action taken in reliance on this Authorization prior to PrimeCare's receipt of my written revocation.

I understand that my treatment may not be conditioned on my agreement to sign this Authorization. I also understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the persons listed above and may no longer be protected.

I understand that I have the right to receive a list of entities to which my patient identifying Part 2 information has been disclosed; all requests must be submitted in writing. _____(initial)

I understand the nature of this Authorization. I have signed this Authorization

voluntarily. I understand I have the ability to obtain a copy of this form upon release.

_____ _____
Patient Signature *Date*

If the above signatory is a personal representative, their legal relationship to the patient/client is:

Signature of staff person obtaining authorization: _____
Staff name: _____

Date revoked: _____ **Staff initials:** _____

Notice to Recipient:
This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

In addition to the above, the records from which this information has been disclosed are protected by other applicable Federal and State laws which prohibit you from making any further disclosure of this information unless expressly permitted by the written authorization of the patient or is otherwise permitted by law.