# 42 CFR PART 2 PATIENT CONSENT FOR DISCLOSURE OF SUBSTANCE USE DISORDER INFORMATION

PATIENT I.D.

## Section 1: Standard Consent

### 42CFR Standard Consent for Uses and Disclosures of Substance Use Disorder (SUD) Treatment Records

Use this section for all limited, one-time, or specific disclosures that are not for treatment, payment, or healthcare operations, (e.g., a patient request, a specific provider, disclosures to an attorney, employer, school, court, etc.).

Patient name: _____

Date of birth: _____ MRN #: _____ (if known)

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 law. I am authorizing the following use or disclosure of my protected health information.

**1. Authorization to disclose**

I authorize the following person or organization to use and disclose my records:

Name: _____

**2. Treatment dates for requested disclosure:**

_____

**Information to be disclosed**: Check all that apply:

- ☐ Entire SUD treatment record
- ☐ Assessment and diagnosis
- ☐ Treatment plan and progress
- ☐ Discharge summary
- ☐ Medications
- ☐ Laboratory results and test findings
- ☐ Other (specify): _____

**Special consent requirements SUD counseling notes:**

☐ **SUD counseling notes:** By checking this box, I voluntarily agree to allow the Part 2 Program to use and disclose my SUD counseling notes for the purpose(s) I specify. I understand that I am not required to consent to the release of these notes in order to receive treatment, payment, enrollment, or eligibility for benefits.

**WARNING: I understand that if I check above, I consent to the release of my SUD counseling notes; this consent form cannot include any other requested information. This requires a separate, standalone consent.**

**3. Recipient of information**

I authorize my information to be disclosed to (include specific name of recipient):

Name: _____

Address: _____

Email address: _____

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**4. Purpose of disclosure**

Purpose: _____

☐ **Fundraising (optional):** I do not wish to receive any fundraising communications. I understand that choosing to opt out will not affect my treatment, payment, enrollment, or eligibility for benefits. *I also understand that I have the right to opt out of receiving fundraising communications at any time, including if I choose not to sign this section today.*

**Special consent requirements for legal proceedings:**

☐ **Legal proceedings:** I agree to the use and disclosure of my substance use disorder treatment records to be used in the following criminal, civil, legislative, or administrative proceedings:

Case/investigation #: _____ Other proceeding(s) info: _____

**WARNING: I understand that if I check above, this form cannot include any other purpose listed. This requires a separate, standalone consent.**

**5. Expiration**

Unless I revoke my consent, this consent will expire on (date, event, or condition):

_____

**6. Right to revoke**

☐ I understand that I have the right to revoke this consent at any time by submitting a written revocation to:

Cedars-Sinai Medical Center
Health Information Department
8700 Beverly Blvd., Room 2800
Los Angeles CA 90048
GroupHIPAAPrivacy@cshs.org

☐ I understand that revocation will not apply to information already disclosed based on this consent.

**7. Understanding of rights**

☐ I understand that I am not required to sign this consent form, and my refusal to sign will not affect my ability to receive treatment, payment, enrollment, or eligibility for benefits. However, if I do not sign, the consequences will be: We may be unable to disclose your records to the individuals or organizations identified for non-treatment purposes.

☐ I acknowledge that I have been offered a copy of this consent form and that it has been explained to me in a language I understand.

**8. Signature**

_____ _____

Patient or legal representative name (please print) Patient or legal representative signature

Relationship to patient: ☐ Self ☐ Parent/Guardian ☐ Spouse ☐ Other (please specify): _____

_____ _____

Date (MM/DD/YYYY) Time

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**Interpreter/Witness for interpreter**

☐ This box shall be checked when the following paragraph is applicable:

We have accurately and completely read the foregoing document to the patient/legal representative in their primary language identified below. They state that they understood all of the terms and conditions and acknowledged their agreement by signing the document in my presence.

Interpreter name (please print)/I.D. no. _____ Interpreter signature _____

Date (MM/DD/YYYY) _____ Time _____ Language _____

Witness name (please print) _____ Witness signature _____

Date (MM/DD/YYYY) _____ Time _____

**Notice: 42 CFR Part 2 prohibits unauthorized use or disclosure of these records.**

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## Section 2: TPO Consent (Treatment, Payment, and Health Care Operations)

### 42CFR Standard Consent for treatment, payment, and health care operations

Use this section when creating a consent specifically for Treatment, Payment, and Health Care Operations (TPO) purposes. This type of consent includes all Standard Consent requirements (**Section 1**) plus additional elements.

Patient name: _____

Date of birth: _____ MRN #: _____ (if known)

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 law. I am authorizing the following use or disclosure of my protected health information.

**1. Authorization for TPO**

I authorize the following Part 2 program to use and disclose my substance use disorder treatment records for treatment, payment, and healthcare operations to: *my treating healthcare providers, health plans, third-party payers, and organizations helping to operate this program.*

Name: _____

**2. Treatment dates of service for requested disclosure:**

_____

**Information to be disclosed**: Check all that apply:

- ☐ Entire SUD treatment record
- ☐ Assessment and diagnosis
- ☐ Treatment plan and progress
- ☐ Discharge summary
- ☐ Medications
- ☐ Laboratory results and test findings
- ☐ Other (specify): _____

**3. Recipient of information**

I authorize my information to be disclosed to (include specific name of recipient):

Name: _____

Address: _____

Email address: _____

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**4. Purpose of disclosure**

Purpose: _____

☐ Patient request ☐ Continued care ☐ Insurance ☐ Employment verification

☐ Other: _____

**HIPAA redisclosure statements (required for treatment, payment, or healthcare operations):**

1. Your Part 2 record information may be redisclosed by covered entities and business associates in accordance with HIPAA, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against you.
2. These Part 2 records may be subject to redisclosure by other recipients and may no longer be protected by 42 CFR Part 2.

**5. Expiration**

Unless I revoke my consent, this consent will expire on (date, event, or condition):

_____

**6. Right to revoke**

☐ I understand that I have the right to revoke this consent at any time by submitting a written revocation to:

Cedars-Sinai Medical Center
Health Information Department
8700 Beverly Blvd., Room 2800
Los Angeles CA 90048
GroupHIPAAPrivacy@cshs.org

☐ I understand that revocation will not apply to information already disclosed based on this consent.

**7. Understanding of rights**

☐ I understand that under 42 CFR Part 2, this consent for uses and disclosures for Treatment, Payment, and Health Care Operations (TPO) may be required as a condition of receiving care. If I choose not to sign this consent, it may limit the ability of my providers and health plans to treat me, process payment, or carry out health care operations, and may affect my ability to receive treatment, payment, enrollment, or eligibility for benefits.

☐ I acknowledge that I have been offered a copy of this consent form and that it has been explained to me in a language I understand.

**8. Signature**

_____ _____

Patient or legal representative name (please print) Patient or legal representative signature

Relationship to patient: ☐ Self ☐ Parent/Guardian ☐ Spouse ☐ Other (please specify): _____

_____ _____

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We have accurately and completely read the foregoing document to the patient/legal representative in their primary language identified below. They state that they understood all of the terms and conditions and acknowledged their agreement by signing the document in my presence.

Interpreter name (please print)/I.D. no. _____ Interpreter signature _____

Date (MM/DD/YYYY) _____ Time _____ Language _____

Witness name (please print) _____ Witness signature _____

Date (MM/DD/YYYY) _____ Time _____

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## Section 3: Intermediary Consent

### 42CFR Standard Consent for treatment, payment, and health care operations

Use this section when the recipient is an "intermediary," which does NOT include a Part 2 program, covered entity, or business associate (ex. HIE, ACO, CMO)

Patient name: _____

Date of birth: _____ MRN #: _____ (if known)

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 law. I am authorizing the following use or disclosure of my protected health information.

1. **Authorization via intermediary**

   I authorize the following Part 2 program to disclose my records through an intermediary:

   Name: _____

2. **Recipient of information**

   I authorize my information to be disclosed to (include specific name of recipient):

   Name: _____

   Address: _____

   Email address: _____

3. **Purpose of disclosure**

   Purpose: _____

   If the purpose of the Part 2 Intermediary Consent is for Treatment, Payment, or Health Care Operations:

   ☐ These Part 2 Records may be subject to redisclosure by the Recipient and no longer protected by 42 CFR Part 2.

4. **Expiration**

   Unless I revoke my consent, this consent will expire on (date, event, or condition):

   _____

   "None" is allowed ONLY for TPO purposes, research studies, or when a HIPAA authorization is not required.

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**5. Right to revoke**

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Cedars-Sinai Medical Center
Health Information Department
8700 Beverly Blvd., Room 2800
Los Angeles CA 90048
GroupHIPAAPrivacy@cshs.org

☐ I understand that revocation will not apply to information already disclosed based on this consent.

**6. Understanding of rights**

☐ I understand that I am not required to sign this consent form, and my refusal to sign will not affect my ability to receive treatment, payment, enrollment, or eligibility for benefits. However, if I do not sign, the consequences will be:

_____

If I do not sign this consent, my providers may be limited in their ability to share my information with the individuals or organizations identified on this form for the purposes described, which may affect coordination of my care or other requested services.

☐ I acknowledge that I have been offered a copy of this consent form and that it has been explained to me in a language I understand.

**7. Signature**

_____ _____

Patient or legal representative name (please print) Patient or legal representative signature

Relationship to patient: ☐ Self ☐ Parent/Guardian ☐ Spouse ☐ Other (please specify): _____

_____ _____

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Interpreter name (please print)/I.D. no. _____ Interpreter signature _____

Date (MM/DD/YYYY) _____ Time _____ Language _____

Witness name (please print) _____ Witness signature _____

Date (MM/DD/YYYY) _____ Time _____

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