CRISP DC

Patient Consent to Disclose Substance Use Disorder (SUD)Treatment Information Covered by 42 CFR Part 2

Patient Details

Name (First/Middle/Last) _____

Address _____

Date of Birth (mm/dd/yyyy) _____

City _____

Phone _____

State _____

Zip _____

Information about this Consent

By completing and signing this form, you will be allowing your 42 CFR Part 2 -- Substance Use Disorder (SUD) treatment provider to share information about your 42 CFR Part 2 -- Substance Use Disorder treatment with CRISP DC who may share it with other members of your health care team for purpose of treatment, payment, and health care operations (TPO).

Examples of who may see your information include, but may not be limited to, your primary care provider, hospital and emergency providers, case managers or care coordinators, your insurance company or payer, and other individuals who are involved in coordination or payment of your care. The information will be shared with members of your healthcare team who participate with the CRISP Shared Services affiliate HIEs including Maryland, DC, West Virginia, Connecticut, Alaska and any HIE affiliates in the future.

Anyone receiving your information must follow all state and federal laws to keep your information private; however, there is the potential for the records used or disclosed pursuant to the consent to be redisclosed by the entities receiving the information and the information may no longer be protected by 42 CFR Part 2 (the federal regulation which protects the privacy of SUD information). Once your SUD information is shared with members of your health care team for purposes of treatment, payment, or operations, they may incorporate it into their records and further share it with other health care providers, payers, or organizations that provide services for them. Your information may be redisclosed or shared in accordance with HIPAA regulations, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against you, the patient.

You can request a list of organizations who have received your information by completing an accounting of disclosures requests at https://disclosures.crisphealth.org. A list of Frequently Asked Questions (FAQ) about sharing 42 CFR Part 2 -- Substance Use Disorder treatment data through CRISP DC can be found at https://crispdc.org/wp-content/uploads/2023/12/FAQs-for-Patients-v2.pdf.

CRISP DC does not require you to sign this consent, and it will not impact the sharing of any of your health information through the HIE, except for your SUD information. If you do not consent to the disclosure of your SUD information, it may not be readily available through CRISP DC to those who need the information to give you appropriate care, especially in an emergency.

CRISP DC

Consent to Disclose My Substance Use Disorder Treatment Information

From Whom

I authorize my Substance Use Disorder treatment providers to disclose any of my past, present, and future 42 CFR Part 2 -- Substance Use Disorder information.

To Whom

I authorize disclosure to CRISP Shared Services affiliate HIEs, who may then disclose the information to any of my treating providers, health plans, third-party payers, and people helping to operate this program. I can request a list of those who have received my information by going to https://disclosures.crisphealth.org.

Type and Amount of Data

The information shared will be used for the purposes of treatment, payment, and health care operations as defined by HIPAA. The information to be shared could include but may not be limited to clinical documents, lab results, hospital discharge summaries, medication information, and claims data relating to my 42 CFR Part 2 -- Substance Use Disorder treatment.

Consent Options

☐ Disclose All Substance Use Disorder Data for Treatment, Payment, and Operations Purposes

This could include my treatment plan, medications, laboratory results, clinical notes, health care encounters, claims information, and other data about my 42 CFR Part 2 -- Substance Use Disorder care.

REVOKING MY PERMISSION

I understand that I may revoke this consent at any time, by requesting one of my CRISP DC participating providers to deactivate my consent in person or via written request. I understand that my information will be shared during the time the consent is active and my health care team may use this information for treatment, payment, and health care operations in accordance with state and federal law. I understand that the revocation will not affect any reliance, action, or disclosure of information by the organization that was authorized to release my information before it received notice of my revocation of my consent. I understand that CRISP DC cannot retrieve information once it is released; if I revoke my consent, whatever has been shared before that consent may continue to be in the files of the entities with whom it was shared before I revoked my consent and may be further shared in accordance with HIPAA and state law.

EXPIRATION DATE

This Consent and Authorization to share my 42 CFR Part 2 – Substance Use Disorder treatment information will remain in effect until the date indicated, unless revoked prior to that time. If no date is the consent will not expire and will remain in effect until revoked.

Expiration Date:

_____ **[If no date is entered, the consent will remain in effect until it is revoked]**

Signature/Attestation

Patient Signature

By signing below, I acknowledge that I have read the consent form and understand that, as indicated on that form, my 42 CFR Part 2 -- Substance Use Disorder information may be shared with CRIS DC who may then share it with members of my health care team who participate with CRISP DC.

_____

Signature of Patient

_____

Printed Name

Legal Guardian Signature

By signing below, I acknowledge that I have the legal authority to consent to share the named individual's 42 CFR Part 2 -- Substance Use Disorder treatment information. I acknowledge that I have read this consent form and understand that as indicated on this form, the 42 CFR Part 2 -- Substance Use Disorder information of the person on whose behalf I am signing may be shared with CRISP DC, who may then share it with the person's health care team who participate with CRISP DC.

_____

Signature of Patient or Legal Guardian, Parent, or Legally Authorized Representative

_____

Printed Name