Authorization to Release Confidential Substance Use Disorder Treatment Information

This form is used to release your protected substance use disorder treatment (alcohol or drug treatment) information (Part 2 Protected Records) as required by state and federal privacy laws. Your authorization allows Community Health Plan of Washington (the Plan) to release your Part 2 Protected Records to person(s) or organization(s) that you specifically name.

SECTION 1: Member Identification			
Last Name:	First Name:	Middle Initial:	Member ID Number:
Address:	City:	State:	Zip:
Phone Number:	If release is for information about dependent child(ren), name(s) of dependent child(ren):		

SECTION 2: Member Authorization for Disclosure of Confidential Information		
The above-named member hereby authorizes the Plan to exchange and disclose information concerning the member's name and other personal identifying information, their status as a patient, diagnosis, medication(s), and treatment(s) to *(attach separate sheet if needed):*		
Entity Name:	Entity Address (street, city, and state):	Entity Phone Number:
Entity Name:	Entity Address (street, city, and state):	Entity Phone Number:
Entity Name:	Entity Address (street, city, and state):	Entity Phone Number:

The information to be exchanged or disclosed *(nature and amount of information to be disclosed, as limited as possible)*:

- ☐ All information (claims, appeals, billing, enrollment, etc.)
- ☐ All benefit claims
- ☐ Appeals
- ☐ Specific claims (specify date(s) of service, claim number, etc.):
- ☐ Billing/enrollment information
- ☐ Other (please specify):

The purpose of the disclosure authorized herein is to:

I understand that my Part 2 Protected Records are protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 Code of Federal Regulations (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 in the regulations.

I also understand that I may revoke this consent at any time (verbally or in writing) to the extent that action has been taken in reliance on it, and that **in any event this consent expires automatically as follows** *(specific date, event, or condition upon which consent expires)*:

Signature of Member:	Dated:

Signature of Parent or Guardian (for dependent child(ren)) *(where applicable)*:	Dated:
Signature of Person Authorized to Sign in Lieu of Member *(where applicable)*:	Dated:

SECTION 3: Notice Prohibiting Redisclosure of Part 2 Protected Records

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 this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains 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. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.