

Consent to Release Substance Use Disorder Information

(For Treatment, Payment and Health Care Operations)

Contexture operates a health information exchange (HIE). The HIE helps doctors, health plans, and other approved users access patient health records when it's legally allowed—for example, to provide care, handle billing, or manage everyday health care tasks. By signing this consent form, you are allowing all of your health information, including information about any substance use disorder, to be shared in the HIE.

Patient Information

Patient Name:	Date of Birth:
Phone Number:	Email Address:
Street Address:	
City/State:	Zip Code:

Your Information

Check One:

- I AM THE PATIENT.** *You do not need to fill out the rest of this section.*
- I am **NOT** the Patient. *Please fill out the rest of this section:*

My Name:	Date of Birth:
Phone Number:	Email Address:
Street Address:	
City/State:	Zip Code:

Relationship to Patient / Description of Authority (required) *(please check all that apply):*

- Parent/guardian
- Health care power of attorney
- Other: _____

Disclosers & Recipients

All the Patient's health information, including substance use disorder information, may be released by the following people and organizations (called Disclosers) and also received by the following people and organizations (called Recipients):

- The Patient's health care providers (including substance use disorder providers), third party payers, health plans, care team members, and their contractors; and
- Contexture, its affiliated entities, and their contractors.

Health Information

All the Patient's health information, including substance use disorder information, may be shared with Recipients. This may include medical, billing, imaging, scheduling, and other records that are used to make health care decisions about the Patient.

Sensitive Health Information

Releasing the Patient's health information may reveal sensitive details, like those related to communicable or sexually transmitted/infectious diseases, HIV/AIDS, reproductive health, developmental or intellectual disabilities, cognitive disorders, mental or behavioral health, substance use (such as drugs and alcohol abuse), abuse/neglect, and genetic testing, and other sensitive information. By signing this form, you consent to the release of this information by Disclosers to Recipients.

Purpose of the Release

The Patient's health information may be shared for treatment, payment, and health care operations, including future uses and disclosures for these purposes. Once released, a Recipient may use and redisclose the information as permitted or required by applicable laws and policies.

Expiration & Revocation

I understand that:

- To revoke this consent, I must send a written revocation request to the health care organization listed at the end of this form or to another health care provider that participates in Contexture's HIE.
- I may revoke this consent; however, this will not affect any use or sharing of my information that has already happened based on this consent.
- After this consent form expires or is revoked, Disclosers and Recipients may still request, access, exchange, use and disclose the Patient's health information as permitted or required by law.

This consent expires on: _____ (month) / _____ (day) / _____ (year). If no date is provided, it will **expire two (2) years from the date this consent form is signed (unless revoked earlier).**

HIE Opt In

I understand the Patient's health information will be shared through Contexture's HIE. If the Patient has opted out of the HIE, signing this form cancels the Patient's "opt out" status and allows their health information to be shared and accessed through the HIE.

Other Important Information

- ✓ **HIPAA Recipients.** If a Recipient receiving substance use records is regulated by the Health Information Portability and Accountability Act (HIPAA), they may redisclose the records as permitted by HIPAA, except in civil, criminal, administrative, or legislative proceedings against the Patient.

- ✓ **Redislosures Generally.** Recipients may redisclose the health information. Such redisclosures may not be protected by federal or state laws like HIPAA or 42 C.F.R. Part 2.
- ✓ **Consequences of Not Signing.** If you do not sign this consent form, the Patient's substance use records may not be accessible through Contexture's HIE for treatment, payment, and health care operations.

My questions about this form have been answered. I have also received a copy of this signed consent form.

Patient **Date:**
Signature: _____

NOTE: The Patient must sign this form if the Patient (i) is a minor or (ii) is an adult that has not been adjudicated as lacking capacity to make health care decisions.

Personal Representative

Signature (if applicable): _____ **Date:** _____

NOTE: A Personal Representative must sign this form if the Patient (i) resides in Arizona and is under the age of 12, or (ii) has been adjudicated as lacking capacity to make health care decisions, or (iii) is deceased.

Notice to Recipients of SUD Records: 42 C.F.R. Part 2 prohibits unauthorized use or disclosure of these records.

Note to patient or personal representative: To revoke this consent, please send a written request to the organization listed below or to another health care provider that participates in Contexture's HIE. <i>(This section to be completed by the healthcare organization submitting this form.)</i>	
Organization's Name:	
Organization's Mailing Address:	
Organization's Email Address:	