CONSENT FOR CASE MANAGEMENT AND CARE COORDINATION

AUTHORIZING DISCLOSURE OF CONFIDENTIAL SUBSTANCE USE DISORDER PATIENT INFORMATION

I, _____, authorize _____ to disclose my substance use disorder records and information to _____ for the following purpose:

- ☐ Treatment
- ☐ Payment of claims
- ☐ Health care options
- ☐ Re-disclosure to current and future health care providers for case management and care coordination activities related to this episode of care.

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 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ('HIPAA"), 45 C.F.R. 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 taken in reliance on it.

I have been provided a copy of this document for my records. A copy of this form is as valid as the original.

This agreement is active until I revoke it, or when I am no longer a member of (health plan) _____

_____.

_____ _____

Member Name ID

_____ _____ _____

Signature Relationship to Member Date