Patient Consent for Uses & Disclosures of Substance Use Disorder Treatment Information 42 CFR Part 2

PRAIRIE STAR Health Center
non-profit • FQHC

Patient Name: _____

Date of Birth: ____ / ____ / _____

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 laws. My treatment records can only be used or disclosed with my written consent, except as permitted by 42 CFR Part 2, HIPAA, and applicable state law. I understand that I have the right not to sign this consent form. If I do not sign, the consequences will be:

- We may not be able to bill your insurance or obtain payment from your health plan.
- You may be responsible for the full cost of services
- We may be unable to coordinate certain aspects of your care.

1) Disclosing Program

I authorize Prairiestar Health Center to use and disclose my records.

2) Recipient(s)

PSHC may disclose my information to:

- the appropriate departments and providers within PrairieStar Health Center
- My health insurance plan, including its employees, agents, and business associates for payment and healthcare operations.
- Organizations that help with billing, claims, or care coordination

3) Records to be Used and Disclosed

PSHC may disclose only the minimum necessary information to accomplish the stated purpose, which may include:

- Identifiers (e.g., name, telephone number, address, DOB, member ID)
- Eligibility/coverage details, dates of service, diagnosis/procedure codes, claim/billing data
- Treatment encounter information necessary for payment or operations

4) Purposes of Use and Disclosure

☑ **Payment** (e.g., eligibility, prior auth, claims adjudication, coordination of benefits)
☑ **Healthcare Operations** (e.g., audits, quality review, utilization management, customer service)
☑ **Treatment** (if applicable for integrated care coordination)

5) Expiration

- ☐ None
- ☐ One year from date this consent is signed

6) Right to Revoke

I understand I may revoke this consent at any time by submitting a written request to PrairieStar Health Center Privacy Officer, except to the extent action has already been taken in reliance on it. Revocation does not apply to disclosures already made.

7) Redisclosure Notice

I understand that the Part 2 records used or disclosed under this TPO consent may be redisclosed by the recipient and may no longer be protected by 42 CFR Part 2. However, such redisclosures may still be protected by other applicable privacy laws such as HIPAA.

I understand that if HIPAA covered entities and business associates receive these records for treatment, payment, and health care operations purposes, the records may be redisclosed in accordance with HIPAA, except for uses or disclosures for civil, criminal, administrative, or legislative proceedings against me.

8) Patient Acknowledgment & Signature

I have read and understand this authorization. I have received a copy upon request.

Patient/Personal Representative Name: _____
Relationship (if not patient): _____
Signature: _____ **Date:** ____ / ____ / _____

42 CFR PART 2 PROHIBITS UNAUTHORIZED USE OR DISCLOSURE OF THESE RECORDS.