Charleston Area Medical Center

PLACE
PATIENT IDENTIFICATION LABEL
HERE

MRO/CAMC Release of Information
130-138 57th Street, SE
Charleston, WV 25304
Phone: (304) 388-1308
Fax: (304) 388-1195

Scan to: BH Confidential ROI

On-Demand Request for Opioid Addition Treatment Records

AUTHORIZATION TO DISCLOSE RECORDS CONTAINING SUBSTANCE ABUSE INFORMATION FOR 42 CFR Part 2 and HIPAA

I, _____ **Date of Birth** _____
[Please print full name]

Last 4 SSN _____ **Day Phone** _____ **Other Name(s) Used:** _____

PATIENT ADDRESS: Street:_____City: _____ State: _____ Zip: _____

I authorize CAMC to disclose the following information:

☐ **Psychiatric/medical/alcohol/drug abuse evaluation and treatment**

☐ **Psychiatric/medical/alcohol/drug abuse discharge summary**

☐ **Progress notes/Plans of Care** ☐ **Psychological testing** ☐ **Psychotherapy notes** **(separate form & provider approval required)**

☐ **Education testing** ☐ **Lab testing** ☐ **Diagnostic testing/studies**

☐ **Other (MUST be specific)** _____

To Name: _____

Street: _____ **Suite #:** _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: _____ **Fax:** _____

Purpose of Disclosure: (If records are being delivered to patient directly this section can be blank)

☐ Continuity of Care ☐ Insurance ☐ Litigation ☐ Worker's Compensation
☐ Disability Determination ☐ Personal ☐ Other (Please specify): _____

Authorization to Release Information:

1. I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and 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. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

2. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to: CAMC Privacy Officer at the address listed above.

I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire 180 days from the date of signature. If applicable, insert another date or event of expiration: _____ (describe date, event or condition upon which consent will expire, which must be no longer than reasonable necessary to serve the purpose of this consent)

3. **I understand that I might be denied services if: I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. Patients will not be denied services if a consent is refused for a disclosure for other purposes.**

☐ **Checking this box specifies that I have been provided a copy of this form.**

Signature of Patient or Legal Representative_____
DATE

If signed by legal representative, relationship to patient: _____

NOTICE TO WHOM THIS INFORMATION IS GIVEN: 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 information in this** record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed 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 (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.