Authorization to Disclose Behavioral Health and Substance Use Disorder Information

PATIENT INFORMATION

First Name | **Last Name** | **Date of Birth**

Social Security Number | Phone Number

Health Care Provider: ☐ Arcare ☐ KentuckyCare

I, _____, authorize Health Care Provider to disclose my behavioral health and/or substance use disorder information as described below. This authorization is intended to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), HIPAA regulations, and other State and Federal laws and regulations that may create a right of privacy in the health information approved to be disclosed by this authorization.

Please initial:

_____ I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Arcare, Attn: Compliance Department, 200 West Race Ave., Searcy, Arkansas 72143, or via email at complianceandquality@arcare.net. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that unless otherwise revoked, this authorization will expire one (1) year from the date of signing.

_____ I understand that authorizing the disclosure of this health information is voluntary and I can refuse to sign this form. Refusal to sign this authorization will not prevent me from receiving treatment or services.

_____ I understand that the information in my health records may include information relating to sexually transmitted infections, including but not limited to, Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS).

_____ I understand that 42 CFR Part 2 prohibits the recipient of this health information from redisclosing it to others, except with my consent, or in compliance with Part 2's rules. As such, Health Care Provider will include the following written statement with disclosures: *"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 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 this information to investigate or prosecute, with regard to a crime, any patient with a substance use disorder, except as provided by §§2.12 (c)(5) and 2.65."*

☐ I understand that if I have questions about the disclosure of my health information, I can contact Health Care Provider or my attorney.

I hereby authorize Health Care Provider to disclose information to:

Name/Organization: _____

Address: _____ City/State/Zip: _____

Phone : _____ Fax: _____

I authorize the release of information relating to: (INITIAL beside all that apply)

☐ Psychiatric/Psychological Treatment ☐ Substance Use Disorder Information

☐ AIDS, HIV, ARC/Medical

Dates of Treatment/Services: FROM _____/_____/_____ TO _____/_____/_____

Type(s) of Information to be used or disclosed: (INITIAL beside all that apply)

☐ Acknowledgement of presence in treatment/attendance ☐ Diagnosis ☐ Lab reports

☐ Discharge summary/status ☐ Treatment plan ☐ Assessment/Evaluation

☐ Program compliance ☐ Billing statements Other: _____

Purpose or need for information being requested:

☐ Continuing care ☐ Legal proceedings ☐ Insurance Claim

☐ Other: _____

This information may be transmitted via: (INITIAL each approved communication method)

☐ Fax ☐ Verbal ☐ Hard Copy ☐ Electronically

Patient Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____

Printed Name of Person Signing: _____ Date: _____

Witness Signature: _____ Date: _____