TPO Consent for Disclosure of Part 2 Records

PATIENT INFORMATION

Patient's Name:

Address:

Phone #: Date of Birth:

Health Plan ID: E-Mail Address:

PERSON(S) PERMITTED TO MAKE DISCLOSURES

Name of the Provider:

RECIPIENT OF AND PURPOSE FOR DISCLOSURE

Provider may use and disclose information about me to my treating healthcare providers, my health plans (health insurers), other third-party payers, and their business associates (vendors) for the provider's treatment, payment, and health care operations. The information may then be redisclosed as permitted by the HIPAA Privacy Rule, included (but not limited to) for treatment, payment, and health care operations, except that:

The information cannot be used or disclosed for civil, criminal, administrative, or legislative proceedings against me.

INFORMATION THAT MAY BE DISCLOSED

All information necessary to process my claims and coordinate my care. This may include (among other information) diagnoses (names of illnesses or conditions), procedures (type of treatments), my prescriptions, dates of treatment, and names of health care practitioners or other providers who treat me.

EXPIRATION OR REVOCATION OF CONSENT

This consent will not expire unless a specific expiration date is requested below.

Expiration Date Requested by Patient:

You also have the right to revoke this consent at any time by contacting this Provider. Your revocation will not be effective, however, to the extent that the Provider or other lawful holders have already acted in reliance on the consent.

IMPORTANT INFORMATION ABOUT THIS CONSENT

Although the records described above will continue to be protected by the HIPAA Privacy Rule, once Provider discloses records as permitted by this consent, the records will no longer be protected by the Confidentiality of Substance User Disorder Patient Records (Part 2)

If you do not sign this consent, however, your health plan (health insurer) cannot pay claims for your treatment because it will not be allowed to use or disclose information about you.

I have read the contents of this form. I agree to allow the disclosures of my information as described above.

Signature of Patient: Today's Date: