ASAC
Area Substance Abuse Council
PREVENT • TREAT • RECOVER

Completing the Consent to Release Form

ASAC is a 42 CFR Part 2 Facility. As such, our consent to release forms have requirements specific to this regulation. Each item on this form that has a "Yes" or "No" checkbox MUST be checked either "Yes" or "No." Do NOT leave any of these boxes blank.

1) **Patient's Full Name and Date of Birth**
2) **Name(s) of Person and/or Organization:** Be specific. If only a person's name is listed, we can only release information to that one specific person. If the entire organization is listed, we can release to anyone within the organization. Is this to release information to just the local office or the entire organization? (i.e., Unity Point Clinic Bowman Woods vs Unity Point Clinics). Fill in what contact information is available – address, phone, fax, and/or e-mail address.
3) **Written:** Yes or No must be checked. When information is released in written or electronic form to another healthcare provider, it is still protected under the 42 CFR Part 2 regulations regarding re-disclosure of records.
4) **Verbal:** Yes or No must be checked. If information is released verbally, it will then only be protected by HIPAA and not necessarily by the more stringent 42 CFR Part 2 regulations.
5) **I authorize the following PHI to be exchanged from my health record(s):** this is so that it can be determined which specific parts of the file can be shared.
    a) **Presence in Treatment:** if this is all that is checked, we can only release whether someone is a patient.
    b) **Participation in Treatment:** If this is checked, we can only release appointment information for a patient as well as if they have attended those appointments.
    c) **Billing/Insurance Information:** This includes anything relating to the patient's bill, which could include insurance ID, amounts due, and services that were rendered.
    d) **Assessment, Admission, and Discharge Information:** These all relate to the information from when a patient was initially assessed for treatment, admitted into a program, or discharged. This could include screening questionnaires, ASAMs, treatment plans, and encounter notes.
    e) **Encounter/Progress Notes/Treatment Plan:** This would be the note for each session when a patient is present, either an individual or group. It will include what was discussed in the session as well as the ongoing treatment plan.
    f) **Treatment Reviews:** These are done on a periodic basis based on the level of care and will include an updated ASAM as well as what progress has been made on the patient's individual treatment plan goals.
    g) **Urinalysis (UA) results:** This includes both releasing the physical lab report as well as the results, verbally or written, depending on what is checked above.
    h) **Communication notes:** These are notes that staff make to a patient's file that are not part of any other note.
    i) **Medical/Psychiatric Notes:** This is only for patients who received residential treatment and met with ASAC's Medical Provider(s).
    j) **Critical Incident Report:** The report sent to the state when a critical incident occurs.
    k) **Other:** Specify any other information to be released that wasn't covered above.
6) **Purpose of the Disclosure:** at least one item must be checked or something written for "Other." BE SPECIFIC.
7) **State and federal law protect the following information:** there are federal and state-specific laws that there must be specific consent given for sensitive information. Indicate yes or no for each type of sensitive information to indicate if it can or cannot be released.
8) **By signing this consent form I understand that:** read through each item, this lists the different rights patients have as well as the regulations that ASAC adheres to. Ask an ASAC employee if you have any questions.
9) **Expiration date:** the consent defaults to expire one year from the date signed unless it has been revoked prior to that date. If any other date or condition is desired, that can be written in in the blank space directly above where it states one year.
10) **Patient or Authorized Representative Signature and Date:** MUST be signed by patient, regardless of age (even under the age of 18), unless there is documentation of a guardian or other authorized representative under state law to act on the patient's behalf.
11) **Witness Signature and Date:** signed by anyone who witnesses the consent form being signed.

This form must be filled out in its entirety to be valid. If not, no information will be released.
Any questions? Please contact ASAC's Privacy Officer at (319) 390-4611

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AREA SUBSTANCE ABUSE COUNCIL

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Consent to Release Information

Patient Name: _____ **Date of Birth:** _____

I authorize the exchange of my protected health information (PHI) between ASAC and the following:

Name(s) of Person and/or Organization: _____

Street Address: _____ City: _____ State: ____ Zip: _____

Phone: _____ Fax: _____ E-Mail: _____

I authorize this information to be exchanged in the following manner(s):

☐ Yes	☐ No	Written/Electronic	☐ Yes	☐ No	Verbal

I authorize the following PHI to be exchanged from my health record(s):

☐ Yes	☐ No	Presence in Treatment	☐ Yes	☐ No	Encounter/Progress Notes/Treatment Plan
☐ Yes	☐ No	Participation in Treatment	☐ Yes	☐ No	Treatment Reviews
☐ Yes	☐ No	Billing/Insurance Information	☐ Yes	☐ No	Urinalysis (UA) results
☐ Yes	☐ No	Assessment/Evaluation/ASAM	☐ Yes	☐ No	Communication Notes
☐ Yes	☐ No	Admission Information/ASAM	☐ Yes	☐ No	Medical/Psychiatric Notes
☐ Yes	☐ No	Discharge Information/ASAM	☐ Yes	☐ No	Critical Incident Report
☐ Yes	☐ No	Other (If Yes, must specify):			

Specific purpose for exchange of information (Select all that apply):

☐ Coordination of treatment services ☐ Insurance/Billing ☐ Legal ☐ At the Request of the Patient

☐ Other (if checked, must specify):

State and federal law protect the following information. I understand that my health record may contain this information and authorize this information to be exchanged:

☐ Yes	☐ No	Substance Use Disorder Records	☐ Yes	☐ No	Mental Health Records
☐ Yes	☐ No	Gambling Disorder Records	☐ Yes	☐ No	HIV Testing and Results

By signing this consent form, I understand that:

- I have the right to receive a copy of this consent form.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this consent.
- My records are protected under the Federal Regulations governing Confidentiality of Substance Use Disorder Patient Records Act, 42 CFR Part 2 and HIPAA 45 C.F.R. Part 160 & 164.
- My records may no longer be covered by 42 CFR Part 2 after redisclosure. I understand 42 CFR Part 2 prohibits unauthorized use or disclosure of these records. However, any disclosure of information carries with it the potential for redisclosure, and the information may not be protected by federal confidentiality laws.
- I have the right to revoke this consent at any time. Revocation must be made in writing and presented or mailed to the following address: 3601 16TH Avenue SW; Cedar Rapids, IA 52404. Revocation will not apply to information that has already been disclosed in reliance on this consent.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____.
- If I fail to specify an expiration date/event/condition, this authorization will ***expire one year from the date signed***.

_____ _____

Patient or Authorized Representative Signature Date

_____ _____

Witness Signature Date

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