healthcurrent

CONSENT TO RELEASE BEHAVIORAL HEALTH & SUBSTANCE ABUSE INFORMATION
(FOR TREATING PROVIDERS)

Polara Health
GUIDING YOUR WAY TO WELLNESS SINCE 1966

Patient Name: _____ Date of Birth: _____

By signing this form, I permit all of my past, present and future healthcare providers where I have received behavioral health treatment, including any treatment for substance use disorders, to release my information to Health Current, the statewide health information exchange (HIE), and to the organization listed here:

_____ _____
Name of Healthcare Organization with a Treatment Relationship | Phone Number

_____ _____ _____ _____
Address | City | State | Zip

I am receiving (or will receive) treatment from this organization. The purpose of this disclosure is for:

- My treatment;
- Payment for my treatment (for example, billing insurance companies); and
- Healthcare operations activities (for example, improving the quality of care for patients, managing the care of patients, patient safety activities, and other activities necessary to run a health care organization).

I authorize the disclosure of all my medical information for these purposes, including behavioral health information and substance use disorder information (*e.g.*, drugs and alcohol treatment), my medical history, diagnosis, hospital records, clinic and doctor visit information, medications, allergies, lab test results, radiology reports, sexual and reproductive health, communicable disease-related information, and HIV/AIDS-related information.

I understand that the organization listed above will obtain this information about me through Health Current, the statewide HIE. I understand that if I previously opted out of having my health information shared through the HIE, this form will change that decision. I understand that if I sign this form, I agree to have my health information shared through the HIE. I understand that I can change this decision at any time.

I understand that I may take back or cancel this consent to share my information at any time, except where someone already relied on my consent to release the information. If I want to cancel my consent or if I have questions, I will contact the organization at the contact information listed above. **Unless I cancel this consent earlier, it will automatically terminate <u>one year</u> from the date of my signature**. I understand that my substance use disorder treatment information will continue to be protected by federal law after it is released.

_____ _____
Signature of Patient***** | Date

_____ _____
Signature of Parent/Guardian *(If Patient is a child under the age of 18)****** | Date

*****Both the child and parent/guardian must consent to disclosure of the child's substance use disorder information, unless the child is married, homeless, or emancipated.

_____ _____
Signature of Patient's Health Care Decision Maker | Date
(If Patient has been declared incompetent by a court or is deceased)

Notice to Recipient of Substance Use Disorder Information: 42 CFR part 2 prohibits unauthorized disclosure of these records.