Tanana Chiefs Conference

Patient Name: _____

Date of Birth: _____

CONSENT FOR THE USE AND DISCLOSURE OF SUBSTANCE USE DISORDER RECORDS

I, _____ hereby consent to the use and disclosure of my substance use disorder (SUD) records as described below. I understand that these records are protected under federal law and regulations (42 CFR Part 2), and my consent is required to disclose them for the purposes outlined herein.

1. Purpose of Disclosure:

I authorize the use and disclosure of my SUD records for the following purposes:

- **Treatment:** To provide necessary care, coordination of treatment, and communication between my healthcare providers.
- **Payment:** To obtain payment for services rendered, including billing and reimbursement by insurers or government programs.
- **Healthcare Operations:** For the purpose of activities such as quality assurance, case management, and other necessary operations within the healthcare system.

2. Scope of Consent:

This consent applies to all future uses and disclosures of my SUD records related to treatment, payment, and healthcare operations. I understand that these records may include information related to the diagnosis, treatment, and referral for services for my substance use disorder.

3. Parties Authorized to Receive and Use Information:

I consent to the disclosure of my SUD records to and from the following parties:

- Healthcare providers involved in my care (e.g., doctors, therapists, treatment facilities, social workers)
- Insurance companies and third-party payers
- Healthcare clearinghouses
- Billing and coding personnel
- Others involved in the healthcare system or payment processes as required by law

4. Right to Revoke:

I understand that I may revoke this consent at any time by providing written notice to Tanana Chiefs Conference. However, my revocation will not apply to any disclosures made prior to the date of revocation.

5. Expiration of Consent:

This consent remains valid until I revoke it, but I understand that it will not apply to any disclosures made after my revocation or to any records that are not part of my substance use disorder treatment.

6. Redisclosure

I understand that once information is shared with the parties you have authorized outside of TCC, it may no longer be protected by 42 CFR Part 2 and may be subject to further disclosure by the recipient without your further consent.

7. Acknowledgment of Rights:

I acknowledge that:

- I am not required to sign this consent as a condition of receiving treatment, payment, or healthcare services.
- I understand that I can sign a more limited consent which will not impact my access to services.
- I may refuse to consent to the use and disclosure of my SUD records, but such refusal may affect my ability to receive treatment or services.

I have been informed about the potential risks of disclosing substance use disorder records, including the possibility of further unauthorized disclosures. By signing below, I consent to the use and disclosure of my substance use disorder records as outlined in this document.

Patient Name (Print)	Date
Patient Signature:	

Date Received: _____

HRN: _____ Circle one: Athena Carelogic AdvancedMD