Initial Consent to Disclose Records from Community Health Center of the New River Valley Part 2 Program

Community Health Center of the New River Valley (CHCNRV) provides an array of health care services, including substance use diagnosis, treatment, and referral for treatment. The Center uses an integrated care model in which the members of your care team work together to provide coordinated, comprehensive care by understanding your health needs, connecting you to appropriate services and communicating regularly with you and with each other through care team meetings, through our electronic medical record, etc..

As described in our Notice of Privacy Practices, your health information is protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). In addition to HIPAA, the federal regulations governing the Confidentiality of Substance Use Disorder Patient Records (42 CFR Part 2 ("Part 2")) provide additional confidentiality protections for certain substance use disorder records. The Center's Part 2 Program(s) include:

- The following identified units which are held out as providing and provide substance use disorder diagnosis, treatment, or referral for treatment:
  - The Center's Part 2 unit consist of Medical Providers when providing MAT services and Behavioral Health Providers providing therapeutic services.
- The following staff members who have as their primary function the provision of substance use disorder diagnosis, treatment or referral for treatment and are identified as such:
  - Dr. David Roberts, Tony Ramsey, Dr. Peter Guerra, Dr. Rebecca King-Mallory, Ashley Slagel-Perry, Janie Kelly, Erin Shaffer, Whitney Chase, Ally Yeatts, Lauren Carter, Laura Hayes and Cyndi Richards

Part 2 requires a patient's written consent before information protected by Part 2 can be disclosed, except in very limited circumstances as described in The Center's Notice to Patients of Federal Confidentiality Requirements under 42 CFR Part 2. This consent form allows you to authorize the disclosure of your substance use disorder records protected by Part 2. Please review this form carefully.

I _____ authorize The Center's Part 2 program(s) to disclose my substance use disorder records as follows:

- ☐ To the Center for purposes of treatment, care coordination, payment, and health care operations:
  - ☐ All my behavioral health/substance use disorder records
  - ☐ The following parts of my behavioral health/substance use disorder records:
  - ☐ None of my behavioral health/substance use disorder records

- ☐ To the following pharmacies for purposes of treatment:

  To: _____:

  - ☐ All my behavioral health/substance use disorder records
  - ☐ The following parts of my behavioral health/substance use disorder records:
  - ☐ None of my behavioral health/substance use disorder records

- ☐ To the following providers outside of *Health Center* (*i.e.,* therapists or medical providers) for purposes of treatment and care coordination:

  To: _____:

  - ☐ All my behavioral health/substance use disorder records
  - ☐ The following parts of my behavioral health/substance use disorder records:
  - ☐ None of my behavioral health/substance use disorder records

- ☐ To my health insurance company (*e.g.,* Medicaid, Blue Cross) for purposes of payment:

  To: _____:

  - ☐ All my behavioral health/substance use disorder records
  - ☐ The following parts of my behavioral health/substance use disorder records:
  - ☐ None of my behavioral health/substance use disorder records

For additional purposes (if applicable): To authorize The Center's Part 2 Program to disclose substance use disorder records to additional individuals and/or entities (such as to family members or to additional treatment providers) please complete this section:

To the following individual or entity: _____

☐ For the following purpose(s) (*e.g.*, treatment, payment, personal reasons):
To: _____:

- ☐ All my behavioral health/substance use disorder records
- ☐ The following parts of my behavioral health/substance use disorder records:
- ☐ None of my behavioral health/substance use disorder records

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I understand that I may revoke this authorization at any time provided that any such revocation is in writing and submitted to Ashley Slagel-Perry at Community Health Center of the New River Valley, 215 Roanoke St., Christiansburg, VA 24073, 540-381-0820, slagelperry@chcnrv.org except to the extent that action has been taken in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third-party payer.

I understand the conditions of my treatment may be modified up to and including denial of services should I refuse to consent to the disclosure of my substance use disorder records, as permitted by state law.

Expiration: This consent form will expire on: _____.
(If no expiration date, event, or condition, is listed, this consent form will expire 1 Year from the date it is signed).

_____ _____
Signature of Patient or Legal Representative **Date**

_____ _____
If Signed by Legal Representative, Relationship to Patient **Date**