Sentara Health Plans

AUTHORIZATION FOR USE OR DISCLOSURE OF SUBSTANCE USE DISORDER SERVICES INFORMATION

Complete this form to authorize Sentara Health Plans to use or disclose your substance use disorder information to a person(s) or entity(s) with whom you may or may not have a treatment relationship with.

***Mail this form to: Director of Compliance, Sentara Health Plans, PO Box 66189 Virginia Beach, VA 23466 or email to: shpprivacy@sentara.com

Privacy Statement: Please be aware that email and text communication can be intercepted in transmission or misdirected.

Complete the demographic information of the person whose substance use disorder information is being authorized:

1. _____ (Name)
2. _____ / _____ / _____ (Date of Birth)
3. _____ (Member ID # or last 4 digits of SSN #)
4. _____ (Phone Number)

Whom are you authorizing to release your substance use disorder information?

5. _____
Name of Person or Entity Who Will SEND the Substance Use Disorder Information

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Whom are you authorizing to use or receive the substance abuse disorder information?

6. _____
Name of Person or Entity Who Will RECEIVE the Substance Use Disorder Information

7. _____
Title of Person or Entity Who will RECEIVE Substance Use Disorder Information

8. _____
Address of Person or Entity Who Will RECIEVE Substance Use Disorder Information

9. Relationship this Person or Entity has with you:
☐ Provider ☐ Treating Facility ☐ Other: _____

10. ☐ No relationship If no relationship, provide name of person or entity at this location with whom you do have a relationship with: _____

☐ I wish to provide a general RECIPIENT (see #6b in Instructions) to receive my substance use disorder information. I understand that I may request a List of Disclosures which is a list of persons or entities who received my substance use disorder information.

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11. Check the appropriate box to indicate the purpose of the use or disclosure:

☐ At my request ☐ Other Specify: _____

How much and what kind of substance use disorder information may be used or disclosed?

12. Check the appropriate box to indicate what substance use disorder information may be used/disclosed:

☐ Assessment/screening results	☐ Demographics	☐ Medications
☐ Labs/diagnostic tests	☐ Discharge summary	☐ Blood alcohol level
☐ Treatment status	☐ Urinalysis results	☐ Claims
☐ Treatment recommendations	☐ Substances used	☐ Authorizations
☐ Coordination of services/care		

☐ Other (see #7 in Instructions) _____

13. Specify the time period for the information to be disclosed:

☐ All information possessed at the time of the disclosure **OR**

☐ Information from _____ /_____ /_____to _____ /_____ /_____

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14. This authorization will remain in effect until:

- the event or date you specify;
- two (2) years from the date signed; or
- the date you withdraw your permission.

(a.) Authorization termination event: _____ **OR**

(b.) Authorization termination date: _____ /_____ /_____

Complete and sign this authorization for substance use disorder records:

I acknowledge that information to be used or disclosed as a result of this Authorization may include records that are protected by other federal and/or state laws applicable to substance use disorder. I SPECIFICALLY AUTHORIZE THE RELEASE OF CONFIDENTIAL INFORMATION RELATING TO SUBSTANCE USE DISORDER. The recipient of substance use disorder information disclosed as a result of this Authorization will need my further written authorization to re-disclose this information with the exception of purposes to carry out payment and health care operations activities, whereby the minimum information necessary will be disclosed. Substance use disorder information may be disclosed without patient consent to federal, state, and local governments to allow audits and evaluations. 42 CFR §2.32 restricts any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

I acknowledge that I understand that:

- I have the right to review the information that is being used or disclosed;
- I do not have to complete this authorization and my refusal will not affect my benefits unless this authorization is necessary to determine my benefits;
- The information used or disclosed by this authorization may be at risk for re-disclosure by the recipient and no longer protected by the federal privacy laws;
- I have the right to a List of Disclosures if I have requested information be released to a general person or entity versus the specific name of a person or entity;
- I have a right to revoke this authorization at any time by completing and sending to Sentara Health Plans a “Revocation of Authorization” Form except to the extent that the Part 2 program or other lawful holder of the Part 2 Information has acted in reliance on the consent); and
- I have a right to receive a copy of this signed authorization.

15. _____ _____ / _____ / _____
Signature of Member Month Day Year

OR

16. _____ _____ / _____ / _____
Designated Representative** Month Day Year

***Attach a copy of the appropriate legal document granting authority*

This information has been disclosed to you from records protected by federal confidentiality rules (*42 CFR part 2*). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is *NOT* sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c) (5) and 2.65.

INSTRUCTIONS FOR AUTHORIZATION COMPLETION

1. Please PRINT information in pen so it is easy to read. Do not skip any steps. Fill all information in as completely as possible.

2. Items 1, 2, 3 and 4: This is your name, date of birth, the last 4 digits of your social security number or your Sentara Health Plans member number, and your telephone number.

3. Item 5: The name of the person or entity who has your information and you want released from.

4. Item 6, 7, and 8: Is the name, address, and title of the person or entity who is to use or receive your information.

5. Item 9 and 10: If your information is going to be or is being received from a treating person or entity, please indicate the relationship. If you do not have a treatment relationship with the named person or entity, please provide the name of someone with whom you do have a treating relationship with and who is at this same location or with this same entity. Example: Entity is Smith Hospital, which you have never been in, but Dr. John Smith is your treating provider. You would put Smith Hospital in #9 and Dr. John Smith in #10.
   If you wish to provide your information to a general recipient, you may request a List of Disclosures for disclosures made within a 2-year time frame. An example of a general recipient is Somewhere Practice. In this practice are several doctors who you agree may see your substance use disorder information.

6. Item 11: This is a description of the purpose for Sentara Health Plans provide the information to someone else. Example: “Review of claims paid to Dr. Smith.”

7. Item 12: This is the information you want to be provided. The “other” section allows you to write in a specific description of the medical information or name of the documents not on the checklist. Example: “Claims for Dr. Smith from 2/1/2009 to 2/1/2010.”

8. Item 13: This allows you to determine the information’s time frame. Example: “Claims for Dr. Smith from 2/1/2009 to 2/1/2010”

9. Item 14: This allows you to determine when you want this form to expire. If you do not put a date in, this authorization will expire in two (2) years from the date signed.

10. Item 15 and 16: This is your signature or the signature of the person who has the authority to sign this type of document for you. ONLY fill in #16 IF someone other than you has signed the form.

QUESTIONS: Call Member Services at the phone number on the back of your Sentara Health Plans ID card for any questions or concerns regarding this authorization form.