NORTHERN NEVADA HOPES *your partner in health.*

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# Patient Authorization: BH, MH or SUD - Release of Information

**This request is for HOPES to RELEASE OR RECEIVE protected information which includes behavioral health, mental health and/or substance use disorder information, 42 CFR Part 2 applies and AN INFORMED CONSENT IS REQUIRED:** (individual must initial each item of information to be released). This form authorizes the release of Protected Health Information (PHI) pursuant to HIPAA 45 CFR Parts 160 and 164 and 42 CFR Part 2.

______________________________________________________________________________

PATIENT NAME PATIENT SSN DATE OF BIRTH

**______I authorize Northern Nevada HOPES to release information to the following agencies and/or individuals:**
**______I authorize the following agencies and/or individuals to release information to Northern Nevada HOPES:**
***(Initial ONLY ONE – A separate ROI is required for HOPES releasing or receiving protected information)***

______________________________________________________________________________

Agency Department or Name or Person Address

**Purpose for Release:** ______________________________________________________________

*(Nature and amount of information to be disclosed should be as limited and specific as possible)*

**INFORMATION TO BE RELEASED:** (please initial all that apply) **___Behavioral/Mental Health ___Substance Use**

**______Consultation Reports**
**______Diagnosis (psychiatrist)**
**______Discharge Summary**
**______Drug and Alcohol Abuse Info.**
**______ General Summary Letter Only**
**________History & Physical Exam**
**________HIV/AIDS Info.**
**________Medication Records**
**________Progress Notes**
**______Treatment Plans**
**______Psychiatric Evaluation**
**______Psychological Assessment**
**______Other (Specify):**______________________________________________________________

**List types of health information you DO NOT WANT TO SHARE:**_____________________________________

Dates of service to include: from ___________ to ____________

Authorization expiration date_____________________________________________

My consent will expire on the date noted above, or case, event or condition closure unless I withdraw my consent.
If the expiration date is blank or longer than one year, the consent will expire 1 year from the signature date.

**Notice to Recipient**

This information has been disclosed to you from records protected by federal confidentiality rules 42 CFR Part 2 and 45 CFR Part 164 and Nevada Revised Statutes. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 or 45 CFR Part 164 or Nevada Revised Statutes. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patients.

**Notice to Patient**

As a Qualified Service Organization (QSO), HOPES is fully bound by Part 2 and will resist in judicial proceedings if necessary, any efforts to obtain access to information pertaining to patients except as permitted by Part 2, and will use appropriate safeguards to prevent the unauthorized use or disclosure of protected information (42 CFR §2.11).

By signing this form, I understand:

- I am giving consent to share my behavioral health, mental health and/or substance use disorder information. Behavioral health, mental health and substance use disorder information includes, but is not limited to, referrals and services for alcohol and substance use disorders.
- My information will be shared to help diagnose, treat, manage and pay for my health needs.
- My consent is voluntary and will not affect my ability to obtain behavioral health, mental health, substance use or medical treatment, payment for such treatment, health insurance or benefits.
- My health information may be shared electronically.
- Other types of my information may be shared with my behavioral health, mental health and/or substance use disorder information. HIPAA allows my providers and other agencies to use and share most of my health information without my consent in order to provide me with treatment, receive payment for my care, and to manage and coordinate my care.
- The sharing of my health information will follow state and federal laws and regulations.
- This form does not give my consent to share psychotherapy notes as defined by federal law.
- I am responsible to notify all agencies and people listed on this form when I withdraw my consent.
- I can have a copy of this form.

**Information for Informed Consent**

Under the Health Insurance Portability and Accountability Act (HIPAA), a health care provider or agency can use and share most of your health information in order to provide you with treatment, receive payment for your care, and manage and coordinate your care. Northern Nevada HOPES

is a Qualified Service Organization and is required to follow 42 CFR Part 2 in addition to HIPAA and the Nevada Revised Statutes. The confidentiality of behavioral health, mental health and substance use disorder information is protected by state and federal statutes, rules and regulations including Nevada Revised Statutes and Title 42 of the Code of Federal Regulations. These statutes, rules and regulations require that the individual give informed consent prior to the release of any health/hospital records or information, except as specifically provided for within the statutes, rules and regulations.

I understand that my alcohol and/or drug treatment records are protected under the state and federal statutes, rules and regulations including Nevada Revised Statutes, regulations governing confidentiality and drug abuse patient records 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that my I may be denied services if I refuse to consent to a disclosure for purposes of treatment, payment or healthcare operations, as permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

A consent to release information will be considered valid only when it states: (1) who will release the information; (2) who will receive the information; (3) the purpose for which the information will be used; (4) what specific information will be released; and (5) when the consent will expire. The consent must contain the individual's or authorized representative's signature and the date of the signature. The authorized representative signing for the client must submit a copy of the legal document(s) granting this authority.

A disclosure may not be made on the basis of a consent which: 1) has expired; 2) on its face substantially fails to confirm to any of the requirements set forth in this Authorization to Release Information; 3) is known to have been revoked or 4) is known, or through a reasonable effort could be known, by the person holding the records to be materially false.

EXCEPTIONS: There are certain limited circumstances under which behavioral health, mental health or substance use disorder disclosures can be made without patient consent. The circumstances include but are not limited to: 1) Medical Emergencies. Part 2 allows patient identifying information to be disclosed to medical personnel who have a need for the information about a patient for the purpose of treating a condition which poses an immediate threat to the health of any individual and which required immediate medical intervention. 2) Subpoena and court—ordered disclosures. Unlike the HIPAA Privacy Rule, Part 2 permits programs to release patient identifying information in response to a subpoena ONLY IF the patient signs a consent permitting release of the information requested in the subpoena. If the patient does not consent, Part 2 prohibits programs from releasing information in response to a subpoena unless a court has issued an order that complies with Subpart E of Part 2. 3) Child or elder person abuse or neglect reporting. Part 2 permits programs to release patient identifying information in order to comply with State laws that require the reporting of child or elder person abuse and neglect. 4) Crimes on program premises or against program personnel. Part 2 permits programs to disclose limited patient identifying information to law enforcement officers. 5) Qualified Service Organization. Part 2 permits programs to disclose patient identifying information to a QSO. 6) Research activities. Part 2 permits a program to allow a researcher to have access to its patients' records, provided certain safeguards are met. 7) Audit or evaluation activities. Part 2 permits programs to disclose patient identifying information to qualified persons who are conducting an audit or evaluation of the program, without patient consent, provided certain safeguards are met. 8) Patient's intent to harm self or others, patient does not have the capacity to care for self or patient is considered by a court to be "incompetent" to manage himself or herself. Part 2 permits programs to disclose limited patient identifying information to law enforcement officers or emergency medical systems.

This authorization for the Release of Information waives any and all rights that the individual now has or in the future may have to bring any legal action against the releasing person/facility for any damages caused directly or indirectly by the release of this information or other confidential information. Upon request, the individual will be given a copy of this completed "Authorization: Release of Information."

This authorization is effective immediately and is subject to revocation in writing at any time, except to the extent that action has already been taken in reliance thereon. Otherwise, this authorization expires ____days from the date of signing, but no longer than one year, or upon case, event or condition closure, whichever comes first. If I revoke this authorization, I am responsible for notifying all agencies and people listed in this form.

I understand that I must voluntarily and knowingly sign this authorization before any behavioral health, mental health or substance use disorder information can be released, and that I may refuse to sign, but in that event information cannot and will not be released.

I have read this form or have had it read to me in a language I can understand. I have had my questions about this form answered.

SIGNATURE OF PERSON GIVING CONSENT OF LEGAL REPRESENTATIVE DATE

PRINT NAME OF PERSON GIVING CONSENT RELATIONSHIP TO INDIVIDUAL: ___Self ___Parent ___Guardian ___Authorized Representative

**___Individual provided copy** **___Individual declined copy**

## REVOKE AUTHORIZATION TO RELEASE INFORMATION

I hereby revoke this authorization to release information.

SIGNATURE OF PERSON GIVING CONSENT OF LEGAL REPRESENTATIVE DATE

PRINT NAME OF PERSON GIVING CONSENT RELATIONSHIP TO INDIVIDUAL: ___Self ___Parent ___Guardian ___Authorized Representative

**___Individual provided copy** **___Individual declined copy**