



Consent for Use and Disclosure of SUD Treatment Information

This consent applies to all Western Wisconsin Health locations where I may receive Substance Use Disorder (SUD) treatment services.

1. PATIENT STATEMENT

I understand that my substance use disorder treatment records are protected under federal law, including 42 CFR Part 2 and HIPAA, and any applicable state laws. My treatment records may only be used or disclosed with my written consent, except as permitted by 42 CFR Part 2, HIPAA, and applicable state law.

I understand that I have the right not to sign this consent form. My decision not to sign will not affect my right to receive treatment, except to the extent that this authorization is necessary to carry out treatment, payment, or health care operations.

2. AUTHORIZATION

A. WHO MAY USE AND DISCLOSE

I authorize Western Wisconsin Health, through its Behavioral Health Substance Use Disorder Treatment Program, including its workforce members and agents acting within the scope of their duties, to use and disclose my substance use disorder treatment records as described in this authorization.

B. AUTHORIZED RECIPIENTS OF INFORMATION

I authorize disclosure of my substance use disorder treatment records to the following class of recipients:

- Any health care provider, health plan, health care clearinghouse, or other person or entity, and their respective workforce members, contractors, and agents, who are involved in my treatment, payment for my care, or health care operations activities, whether within Western Wisconsin Health or external to it.
- This authorization includes disclosure through electronic health information systems and Health Information Exchanges in which Western Wisconsin Health participates, to participating providers and entities involved in my treatment, payment, or health care operations, as permitted by 42 CFR Part 2.

C. RECORDS TO BE USED AND DISCLOSED

I authorize the use and disclosure of all records relating to my diagnosis, treatment, referral, or participation in substance use disorder services provided by the Substance Use Disorder Treatment Program, including but not limited to clinical records, assessments, treatment plans, medication information, laboratory results, discharge summaries, billing records, and care coordination documentation.

The Substance Use Disorder Treatment Program does not maintain separately documented SUD counseling notes as defined by 42 CFR Part 2.

D. PURPOSE OF USE AND DISCLOSURE

I authorize the use and disclosure of my substance use disorder treatment records for purposes of treatment, payment, and health care operations, including all current and future activities related to my care. This includes, but is not limited to, care coordination; reciprocal services; referrals to and collaboration with other health care providers and community partners; participation in group services;

Please Place a Current Admission Sticker Here When Available

Patient Name: _____

Date of Birth: _____ Med Rec #: _____



coordination with non-covered entities involved in my care; billing and reimbursement activities; quality assessment and improvement; case management; administrative functions; and other health care operations as permitted by 42 CFR Part 2 and other applicable law.

Disclosures for Legal Proceedings

I authorize the use and disclosure of my substance use disorder treatment records for civil, criminal, administrative, or legislative proceedings, including investigations or court actions.

This authorization is separate from treatment, payment, and health care operations. My records may not be used or disclosed for these purposes unless I authorize it here or a court order is issued in accordance with 42 CFR Part 2.

Disclosures for Fundraising

Western Wisconsin Health may contact me for fundraising purposes in accordance with HIPAA. My substance use disorder treatment records will not be used for fundraising without my specific authorization. Check this box only if you want to opt out of receiving fundraising communications.

3. EFFECT

I understand that if HIPAA covered entities or business associates receive my substance use disorder treatment records pursuant to this authorization for treatment, payment, or health care operations, the records may be redisclosed in accordance with HIPAA and other applicable laws.

However, use or disclosure of these records in civil, criminal, administrative, or legislative proceedings requires my specific authorization or a court order in accordance with 42 CFR Part 2.

4. TIME PERIOD

This authorization will take effect immediately and will remain in effect unless and until I revoke it in writing. I have the right to revoke this authorization at any time by submitting a written request to:

Health Information Management Department
Western Wisconsin Health
1100 Bergslien Street
Baldwin, WI 54002

Revocation will not apply to any information that has already been disclosed in reliance on this authorization.

NOTICE OF PROHIBITION ON UNAUTHORIZED USE OR DISCLOSURE

42 CFR Part 2 prohibits unauthorized use or disclosure of these records. Information disclosed under this authorization may be redisclosed in accordance with HIPAA, except that use or disclosure for civil, criminal, administrative, or legislative proceedings requires specific authorization or a court order under 42 CFR Part 2.

I have been offered a copy of this authorization. This form has been explained to me in a language I understand.

Patient or Legal Representative Signature

Date / Time

Legal Representative Printed Name (if signing for patient)
[If signed by a personal representative, documentation of authority must be provided]

Relationship to Patient

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