2700 Hamlin Blvd.
Inkster, MI 48141
Phone: 313-561-5100
Fax: 313-565-0309

25650 W. Outer Drive
Lincoln Park, MI 48146
Phone: 313-383-1897
Fax: 313-383-6018

26650 Eureka Road – Suite C
Taylor, MI 48180
Phone: 734-941-4991
Fax: 734-941-4919

Initial Consent to Disclose Records from Health Center's Part 2 Program

Western Wayne Family Health Centers (WWFHC) provides an array of health care services, including substance use diagnosis, treatment and referral for treatment. WWFHC 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 integrated provider meetings and electronic medical records.*

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 (SUD) Patient Records (42 CFR Part 2 (herein identified as "Part 2")) provide additional confidentiality protections for certain substance use disorder records. WWFHC Part 2 Program(s) include:

- The following identified units which are held out as providing Substance Use Disorder diagnosis, treatment, or referral for treatment:
  - *MAT Programs*
- The following staff members whose primary function is the provision of Substance Use Disorder diagnosis, treatment or referral for treatment are:

  Dr. Latisha Malcolm

  Dr.Ann Elrington

Part 2 requires a patient's written consent before protected information can be disclosed, except in limited circumstances as described in WWFHC's Notice to Patients of Federal Confidentiality Requirements under 42 CFR Part 2.

This consent form allows you to authorize the disclosure of your SUD records that are protected by Part 2. Please review this form carefully.

Consent to Disclose SUD Records

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

- ☐ To *Health Center* for purposes of treatment, care coordination, payment and health care operations:
  - ☐ All of my substance use disorder records[1]
  - ☐ The following parts of my substance use disorder records:
    - ☐ *Treatment planning, medications, UDS*
    - ☐
  - ☐ None of my substance use disorder records

- ☐ To the following pharmacies for the purpose of continuity of services:

  To: _____:

  To: _____:

  - ☐ All of my substance use disorder records[2]
  - ☐ The following parts of my substance use disorder records:
    - ☐ [*include more granular options here*]
    - ☐
  - ☐ None of my substance use disorder records

- ☐ To the following providers outside of WWFHC (*i.e.,* therapists or

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[1] For purposes of Part 2, the patient consent form must include "how much and what kind of information is to be disclosed, including an explicit description of the substance use disorder information that may be disclosed" (*See* 42 CFR § 2.31(a)(3)). If the form includes an option for "all substance use disorder records," it must also include more granular options. Suggestions from SAMHSA on what those granular options might be include the following: diagnostic information; medications and dosages; laboratory test results; substance use history summaries; trauma history summary; elements of a medical record such as clinical notes and discharge summary, claims/encounter data, current problem list, etc. In developing the more granular options, we recommend working with your substance use disorder staff members and medical records team to determine categories that are both meaningful and achievable given your health center's record system and available information.
The consent form may include either: (1) a free text space related to the patient's substance use disorder records or (2) checkbox style options. Health centers may substitute a free text space on this form; however, that may create challenges as patients describe the information they want disclosed which may not be possible given the health center's record system. For example, patients may ask for parts of their records which cannot be separated due to technology/record maintenance.

[2] See footnote 3.

medical providers) for purposes of treatment and care coordination:

To: Records Deposition Service, PO Box 5054
Southfield, MI 48086-5054 EMAIL: requests@recdep.com
Fax (248) 357-3337:

- ☐ All of my substance use disorder records[3]
- ☐ The following parts of my substance use disorder records:
  - ☐ [*include more granular options here*]
  - ☐
- ☐ None of my substance use disorder records

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

To: _____:

- ☐ All of my substance use disorder records[4]
- ☐ The following parts of my substance use disorder records:
  - ☐ [*include more granular options here*]
  - ☐
- ☐ None of my substance use disorder records

For additional purposes (if applicable): To authorize WWFHC 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:
RECORDS DEPOSITION SERVICE

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

- ☐ All of my substance use disorder records[5]
- ☐ The following parts of my substance use disorder records:
  - ☐ [*include more granular options here*]
  - ☑ DISCOVERY BEFORE TRIAL
  - ☐
- ☐ None of my substance use disorder records

[3] See footnote 3.
[4] See footnote 3.
[5] See footnote 3.

I understand that I may revoke this authorization at any time provided that any such revocation is in writing and submitted to WWFHC [*Risk Manager, Medical Records Department*] at 2700 Hamlin Blvd. Inkster MI 48141 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:[6]
_____.
(If no expiration date, event, or condition, is listed, this consent form will expire *one year* from the date it is signed).

_____ _____
Signature of Patient or Legal Representative[7] **Date**

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

[6] The Part 2 regulations require that the "date, event, or condition must ensure that the consent will last no longer than reasonably necessary to serve the purpose for which it is provided." *See* 42 CFR § 2.31(a)(7).
[7] Ensure that the signature blocks align with state law pertaining to instances in which a minor may consent to substance use disorder services or instances in which a parent or guardian's signature is required for a minor to receive substance use disorder services.