FORM B – CONSENT FOR RELEASE OF PART 2 PROGRAM (SUBSTANCE USE DISORDER PROVIDER) INFORMATION

A Part 2 Program is a federally assisted: (i) individual or entity other than a general medical facility who holds itself out as providing, and provides, substance use disorder (SUD) diagnosis, treatment, or referral for treatment; (ii) an identified unit within a general medical facility that holds itself out as providing, and provides, SUD diagnosis, treatment, or referral for treatment; or, (iii) medical personnel or staff in a general medical facility whose primary function is provision of SUD diagnosis, treatment, or referral for treatment, and who are identified as such providers.

Section I

First Name*	**M.I.**	**Last Name***	**Date of Birth*** / /	**Social Security Number**	
Address			**City**	**State**	**Zip Code**

I hereby authorize the disclosure of health information about the above individual as follows.

Section II

The information is to be disclosed by:

Name of Holder of Part 2 Program Information*		**Telephone Number**	
University of Toledo Medical Center		419-383-3668	
Address:	**City**	**State**	**Zip Code**
3000 Arlington Avenue	Toledo	OH	43614

The information is to be provided to the following*:

☐ Named Individual:

☐ Named Third Party Payer:

☐ Named Treatment Provider Entity:

☐ Named Non-Treatment Provider (such as an intermediary or research entity)+:

+*If non-treatment provider is selected complete a, b and/or c below.*

a. Named Individual Participant(s):
b. Named Treatment Provider Entity Participant(s):
c. Description of Group or Class of Treatment Provider Entity Participant(s):

Contact Information (e.g. telephone number, email address, fax number, street address, etc.)

Section III

Reason for Disclosure*	**Health information to be disclosed***:

Specify time period, if desired:

Release only information from the period_____*(mm/dd/yyyy)* to_____*(mm/dd/yyyy)*

Section IV

This authorization will remain in effect until revoked or shall expire on date or event specified below. I understand that I may revoke or cancel this authorization at any time by submitting written revocation in the manner specified by the disclosing entity, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will expire on the date or completion of the event stated below. If no date or event is specified below, this authorization will expire in one year.

Expiration Date or Event

- Substance use disorder records of Part 2 programs disclosed pursuant to this Consent are protected by federal regulations and cannot be re-disclosed without my written consent unless otherwise provided for in the regulations. Any information disclosed pursuant to this Consent other than substance use disorder records or records protected under another state law may be subject to re-disclosure by the recipient.
- I might be denied services if I refuse to authorize disclosure of information for purposes of assessment, treatment, or payment relating to substance use disorder if refusal is permitted by state law. My refusal to authorize disclosure of information for other purposes will not affect my ability to obtain treatment or services.
- If I have authorized disclosure to a generally described group or class of participants in an entity which is not my treatment provider, upon my written request, I must be provided a list of entities to which my information has been disclosed pursuant to that general designation.

Signature of Individual or Authorized Representative* *(identify relationship to individual below)*	**Date*** *(mm/dd/yyyy)*

Relationship of Authorized Representative to Individual (*Authorized representative shall submit proof of authority to the disclosing entity)*

☐ Parent ☐ Legal Guardian ☐ Power of Attorney ☐ Executor/Administrator ☐ Other

☐ **I revoke this authorization. Signature:**_____**Date:**_____**Time:**_____

For administrative use only:

Method of Delivery (e.g. paper, fax, electronic, oral, etc.)	**Date Released**