AUTHORIZATION AND CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

Patient Name: _____ Date of Birth: _____

Patient ID Number:_____ Last 4 digits of SSN: _____

Crossroads Treatment Centers Clinic Name: _____

Authorization for Use/Disclosure of Information: I voluntarily consent to and authorize my above listed Crossroads Treatment Centers health care provider to disclose my health information during the term of this Authorization to the recipient(s) identified below.

Recipients: I hereby authorize my health care information to be released to the following recipients:

1. Other healthcare providers outside of Crossroads Treatment Centers that have a treatment relationship with me, including other behavioral health providers;

2. Insurance companies, healthcare care programs, including Medicare and Medicaid and government funded grant programs, healthcare clearing houses, including Waystar Health and Change Healthcare LLC (previously known as Emdeon), and other third parties involved in the processing of claims for reimbursement and audits related to such claims;

3. Central registries that assist with preventing a patient from being enrolled in multiple treatment programs, including Lighthouse Software Systems (725 Los Angeles Ave, Monrovia, CA 91016) for North Carolina, Georgia, South Carolina, and Kentucky patients, Texas Department of Health Services (1100 W. 49th St., Austin, TX 78756) for Texas patients, and New Jersey Substance Abuse Monitoring System (120 N. Stockton St., Unit 3, Trenton NJ 08618) for New Jersey patients;

4. Prescription Drug Monitoring Programs (PDMP) that assist with tracking controlled substance prescriptions to mitigate prescribing behaviors, and prevent a patient from being enrolled in multiple treatment programs;

5. Any withdrawal management or maintenance treatment program located within 200 miles or less of my Crossroads Treatment Centers clinic;

6. Commission on Accreditation of Rehabilitation Facilities (CARF);

7. HealthShare Exchange of Southeastern Pennsylvania, Inc., a secure health information organization network that is used for care coordination of Pennsylvania patients; and

8. Other contractors, subcontractors, entities, or legal representatives who carry out payment and/or health care operations on behalf of Crossroads Treatment Centers.

Purpose for Disclosure: I authorize the use and disclosure of my health information, which I expressly acknowledge includes the disclosure of my drug and alcohol treatment information, for the following specific purposes:

1. **Treatment:** I authorize the use and disclosure of my health information for treatment purposes, including disclosure to other healthcare providers outside of Crossroads Treatment Centers that have a treatment relationship with me. For example, another doctor treating you may need to know about certain conditions and treatments to provide appropriate care or we may need to disclose information to another treating provider for care coordination and case management.

2. **Payment:** I authorize the use and disclosure of my health information in order for Crossroads Treatment Centers to get paid for the treatment and services I receive from Crossroads Treatment Centers. This includes disclosure to Insurance companies, healthcare care programs, including Medicare and Medicaid and government funded grant programs, healthcare clearing houses, including Waystar Health and Change Healthcare LLC (previously known as Emdeon), and other third parties involved in the processing of claims for reimbursement and audits related to such claims. For example, we may need to give your health plan information about your use of our services so that your health plan will pay us or reimburse you for the treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

3. **Healthcare Operations:** I authorize the use and disclosure of my health information to third parties related to the operations of Crossroads Treatment Centers, which can include administrative and managerial activities of the clinic including quality assessment and improvement activities, medical staff and clinical personnel evaluation activities, legal compliance activities, business planning and development activities, and other business management and general administrative activities. For example, we may use or disclose health information to review our treatment and services and to evaluate the performance of our staff in caring for you, and we may disclose health information to our accreditation organization (CARF) to provide further review of our treatment and services. We will also report information to central registries that assist with preventing a patient from being enrolled in multiple treatment programs.

Information to be Disclosed: I understand that the information that I authorize to be disclosed **is** protected by federal confidentiality rules (including 42 C.F.R. Part 2 and HIPAA). The federal rules prohibit Crossroads Treatment Centers from making any further disclosure of this information unless further disclosure is expressly permitted by my written consent or as otherwise permitted by federal confidentiality rules.

I understand that a general authorization for the release of medical or other information is NOT sufficient to allow Crossroads Treatment Centers to disclose my health information including drug and alcohol treatment notes.

I understand that the federal confidentiality rules restrict any use of my health information that includes drug and alcohol treatment notes to criminally investigate or prosecute me as an alcohol or drug abuse patient.

I understand that certain HIV-related information is protected by federal and state law. Federal and state law prohibits further disclosures of this HIV-related information unless further disclosure is expressly permitted by my written consent or is authorized by the federal Confidentiality of HIV-Related Information Act.

I authorize the release of the following health information:

- ☐ All of my health information, **including drug and alcohol treatment notes** by Crossroads Treatment Center providers, treatment plans, physician orders, drug screen histories, history and physicals, all lab (blood test and toxicology test) results, **which may include HIV/AIDS and other sensitive results,** that the provider has in his or her possession, including information relating to any medical history or physical condition and any treatment received by me.

Term: I understand that this Authorization will remain in effect 2 years from the date this Authorization is signed by the patient (as listed below).

Re-Disclosure of Information: I understand that my health care provider cannot guarantee that the above listed recipient(s) will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to Sign and Right to Revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at Crossroads Treatment Centers. If I change my mind, I understand that I can revoke this authorization at any time by providing a written notice of revocation to Crossroads Treatment Centers at the facility/Center in which I receive my care. The revocation will be effective immediately upon Crossroads Treatment Centers' receipt of my written notice, except that the revocation will not have any effect on any action taken by Crossroads Treatment Centers in reliance on this Authorization before it received my written notice of revocation.

Additional Patient Rights: I understand that I can ask for a copy of this Authorization. **I understand that my records are protected under the federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that if my treating provider discloses my substance use disorder treatment records pursuant to this consent, the recipient will be provided a notice of non-disclosure. I understand that upon my request, I will be provided a list of entities to which my health information has been disclosed pursuant to this Authorization.**

Signature of Patient or Legal Representative/Guardian: _____

Name (printed): _____ Date: _____

Authority/Relationship of Representative to Patient: _____

NOTICE TO ACCOMPANY DISCLOSURE OF SUBSTANCE USE DISORDER INFORMATION

PROHIBITION ON RE-DISCLOSURE

This record which has been disclosed to you is protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see 42 C.F.R. § 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 42 C.F.R. §§ 2.12(c)(5) and 2.65.