Ideal Option

CONSENT TO TREATING PROVIDER ENTITY RECIPIENT

42 CFR Part 2 and HIPAA

[THIS FORM IS USED FOR ANY OUTSIDE PROVIDER THAT PROVIDES YOU CARE i.e. PRIMARY CARE PROVIDER, PSYCHIATRIST, ETC. WHOM YOU WISH TO EXCHANGE INFORMATION WITH IDEAL OPTION]

I,_____ (DOB:_____) authorize Ideal Option, PLLC to communicate with and disclose to one another the following information:

Name of Provider(s) and/or Provider Entity:		Relationship to patient:
Address of Provider(s) and/or Provider Entity:	Street Address:	
	City, State, Zip:	
Telephone/fax of Provider(s) and/or Provider Entity:	Phone: _____ Fax: _____	

For the purpose of:

_____

(Describe the purpose of disclosure; as specific as possible)

Nature of Information to be Disclosed: Date Range of Disclosure: _____

_____ Compliance/Attendance with program
_____ Blood Lab Results (Excluding HIV/STIS)
_____ Other: _____
_____ Urine Drug Testing Results
_____ Verification of FundingSource(s)
_____ Treatment Plan

_____

(Describe how much and what kind of information may be disclosed, including an explicit description of what substances use disorder information may be disclosed; as limited as possible)

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. The Federal rules prohibit 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.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

_____

(Describe date, event, or condition upon which consent will expire, which must be no longer than reasonably necessary to serve the purpose of this consent.)

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

I have been provided a copy of this form.

Dated: _____ _____

Signature of Patient

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). 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. 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 patient.