# Patient Consent to Disclose Substance Use Disorder and Mental Health Treatment Information

**Patient Details**

Name (First/Middle/Last)

_____

Date of Birth (mm/dd/yyyy)

_____

Phone

_____

Address

_____

City

_____

State

_____

Zip

_____

**Information about this Consent**

By completing and signing this form, you will be allowing your Substance Use Disorder or Mental Health treatment provider to share information about your Substance Use Disorder AND Mental Health treatment with the Health Information Exchange who will then share it with other members of your health care team. These could include your primary care provider, hospital providers, emergency providers and other individuals who are involved in coordination of your care. The information may also be shared with your treatment providers who participate with the CRISP Shared Services affiliate Health Information Exchanges (HIEs) including Maryland, DC, West Virginia, Connecticut, Alaska, and any HIE affiliates in the future. These providers must adhere to all state and federal laws with regards to keeping your information private. You can request a list of providers who have received your information by completing an accounting of disclosures requests at https://disclosures.crisphealth.org. A list of Frequently Asked Questions (FAQ) about sharing Substance Use Disorder and Mental Health treatment data through CRISP can be found by **clicking here** or going to **https://www.crisphealth.org/consent-tool/.**

**Consent to Disclose My Substance Use Disorder and Mental Health Treatment Information**

*From Whom*

I authorize disclosure by any of my past, present, and future Substance Use Disorder and Mental Health treatment providers about any of my treatment, including my Substance Use Disorder and Mental Health treatment, that share data with CRISP Shared Services HIEs.

*To Whom*

I authorize disclosure of the above information to CRISP Shared Services affiliate HIEs, who may then disclose the information to any of my past, present, or future providers involved in my care who participate with the HIE or any of the HIE affiliates. I can request a list of all providers who have received my information by going to https://disclosures.crisphealth.org.

**Type and Amount of Data**

The information shared will be used to help my health care team coordinate my care and provide health care treatment.

Consent Options (choose one)

☐ Disclose All Substance Use Disorder and Mental Health Treatment Data

This could include my treatment plan, medications, lab results and clinical notes about about my substance use disorder treatment or mental health care.

☐ Disclose Substance Use Disorder and Mental Health Treatment Providers Contact Info Only

The information will include only my Substance Use Disorder and Mental Health treatment provider's name and contact information.

**REVOKING MY PERMISSION**

I understand that I may revoke this consent at any time, by requesting one of my CRISP participating providers to deactivate my consent in person or via written request. I understand that my information will be shared during the time the consent is active and my providers may use this information for my treatment and care coordination in accordance with state and federal law. I understand that the revocation will not affect any action by the organization that was authorized to release my information before it received notice of my revocation.

**EXPIRATION DATE**

This Consent and Authorization to share my Substance Use Disorder and Mental Health treatment information will remain in effect until the date indicated, unless revoked prior to that time.

Expiration Date (enter date below)

**Signature/Attestation**

## Patient or Legal Guardian Signature

By signing below, I acknowledge that I have the legal authority to consent to share the named individual's Substance Use Disorder and Mental Health treatment information. I acknowledge that I have read this consent form and understand that as indicated on this form, my Substance Use Disorder treatment information, which may also include Mental Health treatment information, may be shared with CRISP who may then share it with members of my health care team who participate with CRISP and its HIE affiliates.

_____

Signature of Patient or Legal Guardian, Parent, or Legally Authorized Representative

_____

Printed Name