Consent to Share Substance Use Disorder Records
Protected by 42 CFR Part 2
For Treatment, Payment and Health Care Operations

Patient Name: _____ Date of Birth: _____

Federal, state and District laws protect the privacy of your health information. Some substance use disorder records have extra legal protections under federal regulations known as 42 CFR Part 2 or "Part 2." Whitman-Walker Health ("WWH") can only share substance use disorder records protected by Part 2 ("Part 2-protected records") if you give us written permission or if the law allows us to share the records without your written permission.

By signing this form, you give WWH permission to share your Part 2-protected records as described in this form. Please read this form carefully and ask us any questions.

Authorization: By signing this form, I give WWH permission to share:

- My Part 2-protected records, including substance use disorder information, included in:
  - Diagnostic information
  - Medications and dosages
  - Lab test results
  - Discharge summaries, claims and encounter data, and current problem list

- From WWH's Part 2 Programs:
  - Whitman-Walker Addiction Services Co-occurring Program ("WWAS Co-Op");
  - Substance Use Management for Harm Reduction; and/or
  - Understanding Your Use Group

- With my treating health care providers, health insurance companies and third-party payers, and people helping to operate WWH's Part 2 Programs

- For purposes of treatment, payment and health care operations.

Effect of signing: By signing this form, I understand:

- When my Part 2-protected records are shared with other doctors, hospitals, insurance companies and their vendors (known as HIPAA covered entities and business

associates) for treatment, payment, and health care operations purposes, the recipients may share my Part 2-protected records as allowed by HIPAA, except for legal actions (such as civil, criminal, administrative, or legislative proceedings) against me.
- Once my Part 2-protected records are shared for treatment, payment and health care operations, the recipients may share them, and the records may no longer be protected by Part 2.
- My Part 2-protected records include my other health information and may contain sensitive health information such as HIV/AIDS-related information, mental and behavioral health care information, and reproductive health information. I understand that when my Part 2-protected records are shared, my other health and sensitive health information will also be shared. If I do not want this information shared, I will not sign this form.

Effect of NOT signing: If I do NOT sign this form:
- WWH will still provide me with treatment, but I will have to pay "out of pocket" for the Part 2 Program services because WWH will not be permitted to bill my health insurance.
- My other health care providers at WWH (outside of Part 2 providers) will have limited access to my Part 2-protected records and that may impact my health care.
- My other health care providers outside of WWH will not have access to my Part 2-protected records and that may impact my health care.

Expiration: By signing below, I understand:

- Unless I revoke (cancel) this consent, it will take effect immediately and will expire 1 year from the date I sign this consent or on this date: _____ (such date not to exceed 1 year from the date signed below).
- I can change my mind and revoke (cancel) this consent form at any time by writing to WWH's Privacy Officer, at HIPAA@Whitman-Walker.org. Canceling my consent will not affect information shared before I canceled my consent.

Notices: By signing below, I understand:

- WWH will provide me with an opportunity to inspect patient records, when permitted by law.
- I can ask WWH for a copy of this completed form and they will give me a copy.

By signing this form, I acknowledge that I have read and understand it.

Patient or legal representative: _____ Date: _____

Relationship to patient if legal representative: _____