BIG ISLAND SUBSTANCE ABUSE COUNCIL
Inspiring Change, Reclaiming Lives

Hulihia Ke Ola

Third Party Payor (Health Insurance)
Consent to Obtain/Disclose Confidential Information

41 Hoku Street
Hilo, HI 96720
(808) 854-2840 Main
(808) 854-2841 Fax
M-F 8 am – 5 pm | bisac.org

I, _____, authorize **Hulihia Ke Ola** to obtain/disclose to
(Print name of client)

_____
(Medical Insurance Company/Agency/Office)

Nature of information to be disclosed: *(information disclosed should be relative to the purpose of disclosure)*.
Client Initial:

_____ Name and other identifying information (e.g., DOB, client #, and address)

_____ Medical, Psychiatric including my substance abuse information relevant to the current treating condition

_____ Progress in treatment, discharge planning and summaries related to the treating condition

_____ Scheduled treatment dates to include; appointments, missed and attended treatment dates

_____ Appeals: I hereby grant Hulihia Ke Ola the right to appeal on my behalf in cases where my medical provider denies my coverage.

_____ Other: _____

The purpose of the disclosures authorized in this consent is for: **Provide medical, psychiatric including substance abuse information for the purpose of attaining insurance authorization relevant to the treating condition.**
I understand that my substance abuse disorder and treatment 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. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been in reliance on it, and that in any event this consent expires automatically as follows:

1 year from discharge date: Specification of the date, event, or condition upon which this consent expires)

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.

_____ _____
Date *(Signature of client)*

_____ _____
(Describe authority to sign on behalf of client) *(Signature of person signing consent if not client)*

PROHIBITING RE-DISCLOSURE OF SUBSTANCE USE DISORDER INFORMATION
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 information in this record that identifies a patient as having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 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 § § 2.12(c)(5) and 2.65.