

# SUBSTANCE USE DISORDER TREATMENT

42 CFR Part 2 Addendum

## Section 1: Patient Information

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date Completed: \_\_\_\_\_

## Section 2: Substance Use Assessment

### Primary Substance(s) of Concern:

- Alcohol
- Cannabis/Marijuana
- Cocaine/Crack
- Methamphetamine
- Opioids (heroin, fentanyl, prescription painkillers)
- Benzodiazepines (Xanax, Valium, Klonopin)
- Stimulants (Adderall, Ritalin)
- Other: \_\_\_\_\_
- None

### Current Use Status:

- Active use (used within past 30 days)
- Early remission (1-12 months abstinent)
- Sustained remission (12+ months abstinent)
- In recovery/on MAT (Medication Assisted Treatment)
- None

### Medication for Opioid Use Disorder (if applicable):

- Currently on MAT:  Methadone  Buprenorphine/Suboxone  Naltrexone/Vivitrol

Prescribing Provider: \_\_\_\_\_

Dosage: \_\_\_\_\_

- Not Applicable

**Previous SUD Treatment:**

- Never treated for SUD before
- Previous outpatient treatment
- Previous intensive outpatient (IOP)
- Previous residential/inpatient treatment
- Previous detoxification

Most recent treatment: \_\_\_\_\_

Dates: From \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

- Not Applicable

**Section 3: Notice of Federal Confidentiality Protection**

**IMPORTANT: YOUR SUBSTANCE USE DISORDER RECORDS ARE PROTECTED BY FEDERAL LAW**

The confidentiality of your substance use disorder patient records is protected by Federal law and regulations (42 CFR Part 2).

**What this means:**

- This practice cannot confirm or deny that you are receiving substance use disorder services without your written consent
- Your SUD records cannot be disclosed without your written consent, except in limited circumstances
- Your SUD records are protected even more strictly than other medical records under HIPAA

**Limited Exceptions (disclosure allowed without consent):**

- Medical emergency - to medical personnel to address the emergency
- Court order - only if court order meets strict Part 2 requirements (subpoena alone is not enough)
- Child abuse reporting - as required by state law
- Audit/evaluation - for qualified personnel conducting audits with strict confidentiality safeguards

**Your Rights:**

- You control who can see your SUD records
- You can give permission for specific people/organizations to receive your records
- You can revoke (cancel) your permission at any time in writing
- These protections apply even after you leave treatment

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

## Section 4: Consent for Use & Disclosure of SUD Records

I, \_\_\_\_\_ (Patient Name), Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

voluntarily consent to the use and disclosure of my substance use disorder treatment records as described below.

### 1. Program Making Disclosure

**Provider/Practice Name:** Graven & Associates, PLLC

**Address:** 8007 Lyndon Centre Way, Suite 101, Louisville, KY 40222

**Phone:** 502-690-8024

**Provider NPI:** Group NPI # 1568846707

### 2. Who May Receive My SUD Records

I authorize disclosure of my SUD records to the following recipients for purposes of coordinating my care, billing insurance, and healthcare operations:

**OPTION A: General Authorization (RECOMMENDED)**

*I authorize disclosure to ALL of the following who have a treating provider relationship with me:*

- All current and future healthcare providers involved in my treatment (including physicians, psychiatrists, therapists, hospitals, labs, pharmacies)
- All insurance companies/health plans responsible for payment (including Medicare, Medicaid, private insurance)
- Care coordinators and case managers

*Note: This option allows seamless coordination of care without separate consent for each provider.*

**OPTION B: Limited Authorization**

*I want to limit disclosures to ONLY the specific individuals/organizations listed below:*

<b>Name/Organization:</b> _____ <b>Address:</b> _____ <b>Purpose:</b> _____
<b>Name/Organization:</b> _____ <b>Address:</b> _____ <b>Purpose:</b> _____
<b>Name/Organization:</b> _____ <b>Address:</b> _____ <b>Purpose:</b> _____

*Note: If you choose this option, you will need separate consent for each new provider.*

### 3. What Information May Be Disclosed

- Substance use disorder assessment and diagnosis
- Treatment plans and progress notes
- Attendance/participation in treatment
- Medication information (including medications for opioid use disorder)
- Drug/alcohol screening results
- Discharge summaries and aftercare plans
- All other SUD treatment records

#### Exclusions - I do NOT authorize disclosure of:

- Psychotherapy notes (if maintained separately)
- SUD Counseling Notes (if maintained separately)
- HIV/AIDS status
- Other: \_\_\_\_\_

### 4. Purpose of Disclosure

- Treatment - To coordinate my behavioral health and medical care across providers
- Payment - To bill insurance and process claims for services
- Health Care Operations - For quality improvement, care coordination, case management, and program administration

### 5. Duration of Consent

This consent is effective as of the date signed below and expires:

- When my treatment at this practice ends
- One (1) year from the date signed below, then renews annually unless I revoke
- On this specific date: \_\_\_/\_\_\_/\_\_\_\_\_
- When revoked by me in writing

### 6. Redisclosure by Recipients

#### **IMPORTANT - Please read carefully:**

#### **If the recipient of my records is a HIPAA covered entity (hospital, doctor, insurance company):**

They may redisclose my SUD records in accordance with HIPAA Privacy Rule regulations

**EXCEPTION:** They CANNOT redisclose my SUD records for use in any civil, criminal, administrative, or legislative proceedings against me without my specific written consent or a valid court order

**If the recipient of my records is NOT covered by HIPAA:**

- They are prohibited from redisclosing my SUD records without my written consent
- Federal law restricts any further disclosure

**7. My Right to Revoke (Cancel) This Consent**

**I understand that I have the right to revoke this consent at any time.**

**To revoke this consent, I must:**

1. Submit a written revocation request to:  
Graven & Associates, PLLC  
8007 Lyndon Centre Way, Suite 101  
Louisville, KY 40222  
502-690-8024
2. Include my name, date of birth, and signature
3. My revocation will be effective on the date it is received

**Effect of revocation:**

- Once revoked, no further disclosures will be made under this consent
- My revocation will NOT apply to disclosures already made before the revocation
- Revoking consent may affect my ability to continue receiving certain services (such as coordination of care with other providers or insurance billing)

**8. Consequences of Not Signing**

**I understand that:**

- My treatment is NOT conditioned on signing this consent
- I may refuse to sign this consent without penalty
- However, if I do not sign this consent:
  - My provider may be unable to coordinate my care with other healthcare providers
  - My provider may be unable to bill my insurance for services
  - I may be responsible for full payment for services
  - Communication with other providers involved in my care will be limited

**9. Right to Receive a Copy**

- I have the right to receive a copy of this signed consent
- I may request a copy at any time
- Each disclosure made under this consent will be accompanied by either a copy of this consent OR a clear explanation of what information can be shared

## Section 5: Patient Signature - Voluntary Consent

I have read this consent (or it has been read and explained to me). I understand its contents and I voluntarily consent to the use and disclosure of my substance use disorder treatment records as described above.

*I understand that I can revoke this consent at any time by submitting a written request.*

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Patient Name (Printed):** \_\_\_\_\_

### If Signed by Personal Representative:

- I am the parent/legal guardian of a minor patient (under age 18)
- I am the legal guardian (guardianship documentation attached)
- I am the healthcare power of attorney (documentation attached)
- I am the personal representative of deceased patient
- I am court-appointed (court order attached)

**Personal Rep. Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

### Provider/Staff Verification:

*I verify that I reviewed this consent with the patient, answered all questions, and provided a copy of the signed consent.*

**Provider/Staff Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Provider/Staff Name:** \_\_\_\_\_

### State Licensing & Oversight Information:

Substance Use Disorder programs in KENTUCKY are overseen by:

**Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities**

275 East Main Street, 4W-A Frankfort, KY 40621

Phone: (502) 564-4527

Crisis Line: 1-800-662-HELP (4357)

To verify a provider's license:

**Kentucky Department of Professional Licensing**

<https://oop.ky.gov>