Coastal Carolina Neuropsychiatric Center

PATIENT CONSENT FOR THE RELEASE OF CONFIDENTIAL SUBSTANCE USE DISORDER INFORMATION PURSUANT TO 42 CFR Part 2

I,_____, authorize
[patient's name]

Coastal Carolina Neuropsychiatric Center, P.A. to disclose [*describe how much and what kind of information may be disclosed, including an explicit description of what substance use disorder information may be disclosed*]:

_____

_____

_____

to the following individuals/entities [*check applicable box*]:

- □ All of my past, present and future treatment providers.
- □ The following individuals/entities:

  _____

  _____

for the following specific, limited purpose(s) [*describe the purpose(s) of the disclosure; as specific and 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 cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time, orally or in writing, 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 if I have allowed disclosure of my information to all of my past, present, and future providers, I may request from Coastal Carolina Neuropsychiatric Center, P.A. a list of entities to which my information has been disclosed, and Coastal Carolina Neuropsychiatric Center, P.A. will provide me, within thirty (30) days of my request, a list of entities to which my information has been disclosed.

Dated: _____ _____
Signature of Patient

_____
Signature of person signing form if not patient

Describe authority to sign on behalf of patient:

Coastal Carolina Neuropsychiatric Center

If the patient cannot complete and execute this form, PATIENT CONSENT FOR THE RELEASE OF CONFIDENTIAL SUBSTANCE USE DISORDER INFORMATION PURSUANT TO 42 CFR Part 2, at the offices of Coastal Carolina Neuropsychiatric Center, P.A. in the presence of office staff, the patient must execute this form in the presence of a notary and return the notarized form to Coastal Carolina Neuropsychiatric Center, P.A.

_____ COUNTY, NORTH CAROLINA

I certify that the following person personally appeared before me this day, acknowledging to me that he signed the foregoing document: _____

Date_____ _____

Notary Public

(Official Seal)

My Commission Expires:

_____