Coastal Carolina Neuropsychiatric Center

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

I,_____, authorize Coastal
[patient's name]

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 consent 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

_____ _____
Print Name of person signing form if not patient *Signature of person signing form if not patient*

Describe authority to sign on behalf of patient:

_____