CentraCare™

Authorization to Share Substance Use Disorder Health Information

Patient Full Name		Patient Date of Birth
Patient Address		Patient Phone Number
City	State	Zip Code
Previous Patient Name		

Sharing Substance Use Disorder (SUD) Records for Treatment, Payment, and Healthcare Operations

I understand and agree:

- CentraCare and its personnel, affiliated entities, qualified service organizations, and business associates may access, use, exchange, and share my medical information, including my past, present and future SUD records for treatment, payment, and healthcare operations.
- SUD records shared pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by 42 C.F.R. Part 2.
- Your SUD Part 2 record (or information contained in your SUD Part 2 record) may be redisclosed in accordance with the permissions contained in the HIPAA regulations, except for uses and disclosures for any civil, criminal, administrative, and legislative proceedings against you.*
- CentraCare may contact me as part of its fundraising efforts. I can opt out of fundraising by emailing foundation@centracare.com or by calling 320-240-2810 or 800-835-6652, ext. 52810

If you consent to our sharing your information, you can change your mind and ask us not to at any time by making a request in writing to CentraCare Health, Release of Information, 1900 CentraCare Circle St. Cloud, MN 56303 or via email at CCHROI@centracare.com. You may call the HIM Department at 320-255-5624 for assistance. We will stop any future sharing of your information but will be unable to stop any information that has already been released.

I understand that this authorization will not permit CentraCare to share my substance use disorder records in civil, criminal, administrative, or legislative proceedings, and that a separate authorization must be signed for these disclosures, unless authorized in state or federal law, or court order.

I understand that if I do not sign this authorization:

- CentraCare may not be able to see me as a patient, provide me with treatment, make referrals to other healthcare providers, or coordinate my healthcare with those providers or others.
- My insurer may not cover its portion of my medical bills, and I would be responsible for those charges.

Signature: Patient or Legal representative must sign and date this form

Patient signature	Date
Guardian or Legal Representative signature	Date
Printed guardian/Legal Representative name	
Relationship to patient if not signing – legal documentation must be on file _____ Parent _____ Legal Guardian _____HealthCare Agent/Power of Attorney _____Other	

*Notice to recipients: 42 CFR part 2 prohibits unauthorized use or disclosure of these records.