BlueCross BlueShield Minnesota

TPO Consent for Disclosure of Part 2 Records

A. PATIENT INFORMATION

_____

Patient's name (*please print*):

_____ _____

Health Plan ID#: Date of Birth:

_____

Address:

_____

City/State/Zip

_____ _____

Phone number E-Mail address

B. PERSON(S) PERMITTED TO MAKE DISCLOSURES

_____("Provider")

Fill in name of ***Part 2 Program***. (*i.e.*, provider furnishing treatment to patient)

C. RECIPIENT OF AND PURPOSE FOR DISCLOSURE

Provider may use and disclose information about me to my treating health care providers, my health plans (health insurers), other third-party payers, and their business associates (vendors) for the provider's treatment, payment, and health care operations. The information may then be redisclosed as permitted by the HIPAA Privacy Rule, including (but not limited to) for treatment, payment, and health care operations, ***except that***:

The information cannot be used or disclosed for civil, criminal, administrative, or legislative proceedings against me.

D. INFORMATION THAT MAY BE DISCLOSED

All information necessary to process my claims and coordinate my care. This may include (among other information) diagnoses (names of illnesses or conditions), procedures (type of treatments), my prescriptions, dates of treatment, and names of health care practitioners or other providers who treat me.

E. EXPIRATION OR REVOCATION OF CONSENT

(Circle one): **This consent will not expire** (*or*) **This consent will expire** _____ (***insert expiration date (i.e., "after one-year") or expiration event***). You may revoke this consent at any time by contacting Provider at the address provided below. Your revocation will not be effective, however, to the extent that Provider or others have already acted in reliance on the consent.

F. IMPORTANT INFORMATION ABOUT THIS CONSENT

Although the records described above will continue to be protected by the HIPAA Privacy Rule, once Provider discloses records as permitted by this consent, the records will no longer be protected by the Confidentiality of Substance Use Disorder Patient Records Rule (Part 2).

If you do not sign this consent, however, **Provider will not provide treatment to you and** your health plan (health insurer) cannot pay claims for your treatment because it will not be allowed to use or disclose information about you.

G. SIGNATURE AND DATE

I have read the contents of this form. I agree to allow the disclosures of my information as described above.

_____

Signature of Patient

_____

Signature of person authorized to provide consent under 42 C.F.R. §§ 2.14 or 2.15, if applicable.

_____

Relationship of person authorized to provide consent, if applicable.

_____

Today's Date

To revoke this consent, you may contact: _____

(Enter contact information for Part 2 Program (or other Person) obtaining consent)