My Next Steps of Morganton, LLC

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AUTHORIZATION FOR DISCLOSURE OF SUBSTANCE USE DISORDER TREATMENT INFORMATION TO FAMILY MEMBERS

HIPAA and 42 CFR Part 2 Compliant

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AUTHORIZATION TO DISCLOSE INFORMATION

I authorize **My Next Steps of Morganton** to disclose information related to my substance use disorder (SUD) treatment, diagnosis, attendance, progress, medication-assisted treatment (MAT), counseling services, drug screening results, treatment recommendations, discharge planning, and other treatment-related information to the family member(s) or individual(s) listed below. Disclosure is permitted only as described in this authorization. Written patient consent is generally required before a Part 2 program may disclose information identifying an individual as receiving substance use disorder treatment.

Name **Relationship** **Phone Number**

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_____

INFORMATION TO BE DISCLOSED

I authorize My Next Steps of Morganton to disclose the following information (Initial all that apply):

_____☐ Attendance and participation in treatment

_____☐ Admission and discharge dates

_____☐ Treatment recommendations and progress

_____☐ Counseling and therapy participation

_____☐ Drug screening results

_____☐ Medication-Assisted Treatment (MAT) information

_____☐ Appointment scheduling and compliance

_____☐ Treatment plan goals and progress

_____☐ Family counseling participation

_____☐ Discharge and aftercare planning

_____☐ Other:_____

PURPOSE OF DISCLOSURE

The purpose of this disclosure is:

_____☐ Family involvement and support during treatment

_____☐ Coordination of care

_____☐ Participation in treatment planning

_____☐ Emergency contact communication

EXPIRATION OF AUTHORIZATION

This authorization shall remain in effect until:

_____☐ Completion of treatment episode

_____☐ One (1) year from the date signed

_____☐ Revoked by me in writing

PATIENT RIGHTS

I understand that:

1. My records relating to substance use disorder treatment are protected by federal confidentiality laws, including HIPAA and 42 CFR Part 2.
2. I may revoke this authorization at any time by submitting a written revocation to My Next Steps of Morganton, except to the extent action has already been taken in reliance upon it.
3. Refusal to sign this authorization will not affect my eligibility for treatment, payment, enrollment, or benefits.
4. Information disclosed pursuant to this authorization may no longer be protected by federal privacy regulations once it is disclosed to a non-covered recipient, except as otherwise required by law.
5. I have the right to receive a copy of this signed authorization.

NOTICE TO RECIPIENT

This information has been disclosed from records protected by federal confidentiality rules (42 CFR Part 2). Federal law restricts the use and disclosure of substance use disorder treatment information. Unauthorized redisclosure may be prohibited by law.

PATIENT ACKNOWLEDGMENT

I have read and understand this authorization. I voluntarily authorize My Next Steps of Morganton to disclose the information described above to the individuals listed herein.

_____ _____

Client Signature Date