

## Behavioral Health Organizations Confidentiality of Patient Records for Substance Use Disorders

### Background

The Behavioral Health and Service Integration Administration (BHSIA) strategic plan for 2013-2015 includes implementing managed care behavioral health integration by April 1, 2016. While BHSIA supports the goals of integrating behavioral health services, we also support confidentiality protections for substance use disorder patient records as essential to ensuring individuals will access treatment services after integration. The federal alcohol and drug patient confidentiality protections need not be a barrier to behavioral health integration because federal rules provide tools (medical emergency exception, patient consent forms, qualified service organization agreements, etc.) necessary to facilitate communication between treatment agencies and behavioral health organizations (BHOs).

### Behavioral Health Organizations

Beginning in January and February 2016, DBHR will require in its' outpatient and residential provider contracts that individual patient consent is secured to allow a treatment agency and BHO to communicate about a patient's treatment, payment, or health care operations required after March 31, 2016. Treatment agencies are currently required per Washington Administrative Code 388-877 to secure patient consent to communicate with managed care entities for treatment and payment purposes. A model ROI that will be used by the agencies and programs will be posted on the DBHR website.

### Treatment Agencies

- Ask patients to sign a release of information (ROI) allowing communication between the agency, BHO, and DBHR using a transition ROI from DBHR. After April 1, 2016, an ROI should allow communication between an agency and BHO.
- The ROI must be written allowing communication between an agency and the BHO in the regional service area in which the patient has established residency.
- Retain a copy of the signed ROI in the patient record.
- Check the BHO ROI flag in the TARGET system which will notify DBHR that the patient has consented to sharing information.
- ROIs may be signed prior to the date required by DBHR contracts and information may be shared with BHOs once the release is signed.

### DBHR

- Verify the patients that have signed consent allowing DBHR to share client information from TARGET with BHOs.
- Send BHOs TARGET and service encounter information.

### Questions

- If a client refuses to sign a 42 CFR part 2 ROI is the BHO still compelled to authorize services? Answer: No
- If a client refuses to sign a 42 CFR part 2 ROI can the BHO decline payment for services? Answer: Yes
- If a client refuses to sign a 42 CFR part 2 ROI is there a potential conflict with 45 CFR? Answer: No

## Consent for Release of Confidential Information

I, \_\_\_\_\_<sup>3</sup>, authorize  
(Name of Patient)

\_\_\_\_\_<sup>1</sup>  
(Name or general designation of alcohol/drug program making disclosure)

to disclose to \_\_\_\_\_<sup>2</sup>  
(Name of person or organization to which disclosure is to be made)

the following information: \_\_\_\_\_<sup>5</sup>  
(Nature and amount of the information to be disclosed, as limited as possible)

The purpose of the disclosure authorized in this is to: \_\_\_\_\_<sup>4</sup>  
(Purpose of disclosure, as specific as possible)

⑥ I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

\_\_\_\_\_<sup>7</sup>  
(Specification of the date, event, or condition upon which this consent expires)

⑩ I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.  
I have been provided a copy of this form.

Dated: \_\_\_\_\_<sup>9</sup>

\_\_\_\_\_<sup>8</sup>  
Signature of Patient

\_\_\_\_\_  
Signature of person signing form if  
not patient

Describe authority to sign on behalf of  
patient \_\_\_\_\_

**NOTICE**  
**PROHIBITING REDISCLOSURE**  
**OF ALCOHOL OR DRUG TREATMENT INFORMATION**

***Prohibition on Redisclosure***  
**of**  
**Confidential Information**

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules, 42 Code of Federal Regulations (CFR), Part 2. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

## Consent for Release of Confidential Information

According to CFR 42 § 2.31, a properly completed consent for release of confidential information must contain each of the following items:

- ❶ The name or general designation of the program(s) making disclosure;
  - ❷ The name of the individual or organization that will receive the disclosure;
  - ❸ The name of the patient who is the subject of the disclosure;
  - ❹ The purpose or need for disclosure;
  - ❺ A description of how much and what kind of information will be disclosed;
  - ❻ The patient's right to revoke the consent and the exceptions to the right to revoke or, if the exceptions are included in the program's notice, a reference to the notice;
  - ❼ The date, event, or condition upon which the consent expires if not previously revoked;
  - ❽ The signature of the patient (and/or other authorized person); and
  - ❾ The date on which the consent is signed.
  - ❿ The program's ability to condition treatment, payment, enrollment or eligibility of benefits on the patient agreeing to sign the consent, by stating either that the program may not condition these services on the patient signing the consent, or the consequences for the patient refusing to sign the consent.
- **This is a legal document.** Any change to this document, once the patient has signed it, requires their initials and the date of the amendment as an indication of their approval for the change.
  - A revocation requires only that a line be drawn through the document, with the word "Revoked", and the date and time of revocation. The patient need not initial a revocation. A patient may request revocation by any means, including the telephone, provided their identity is confirmed.

# Sample Consent for Release of Confidential Information

I, John Doe, authorize  
(Name of Patient)

ABC Recovery Center and the Washington State Division of Behavioral Health and Recovery  
(Name or general designation of alcohol/drug program making disclosure)

to disclose to the Banks Lake BHO  
(Name of person or organization to which disclosure is to be made)

the following information: Identifying information, admission date, initial clinical assessment,  
(Nature and amount of the information to be disclosed, as limited as possible)

program specific substance use disorder assessment, individual service plan, service encounters,  
substance use disorder treatment history, anticipated discharge date, and discharge information if  
applicable.

The purpose of the disclosure authorized in this is to: Support coordination of care, payment,  
(Purpose of disclosure, as specific as possible)  
and health care operations.

\_\_\_\_\_  
\_\_\_\_\_

⑥ I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

October 1, 2016 (If needed, extend based on coordination of care)  
(Specification of the date, event, or condition upon which this consent expires)

⑩ I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.  
I have been provided a copy of this form.

Dated: \_\_\_\_\_ ⑨

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Signature of person signing form if  
not patient

Describe authority to sign on behalf of  
patient \_\_\_\_\_