

**CONSENT
TO
DISCLOSE CONFIDENTIAL PROTECTED HEALTH INFORMATION**

EXPLANATION PAGE

_____ participates in an electronic health information exchange with other health care providers, known as “eBHIN” (Electronic Behavioral Health Information Network). We and the other participating health care providers are referred to as “*Participants*”. With your permission, our participation in eBHIN does two things:

- It provides the electronic method for us to disclose our confidential health information about you to other *Participants* who are treating you and request your information; and
- It allows other *Participants* to electronically disclose their confidential health information about you to us if we request your information for our treatment of you.

The purpose of this Consent is to obtain your permission for the sharing of a ***limited summary of your behavioral health record*** between *Participants* belonging to eBHIN who are involved with your treatment.

The ***limited summary of your behavioral health record*** will include (as applicable) the following components:

Demographic Information including name, date of birth, and Social Security Number	Emergency Contact Information	Substance Abuse History Summary
Diagnosis Information	Insurance Information	Trauma History Summary
Current Medications and Allergies	Employment Information	Mental Health Board Disposition
Living Situation and Social Supports	Billing Information	BryanLGH Emergency Dept. Chart

eBHIN works as follows. With your consent we, as a Participant, will furnish the limited summary of your behavioral health record to eBHIN, which will store it electronically. eBHIN’s record about you will be updated as we and other Participants, always with your consent, send additional information from later visits. Then, when you visit a Participant, the Participant with your consent can obtain the updated summary of your behavioral health record from eBHIN.

There are rules each *Participant* must follow to participate in eBHIN

- *Participants* may only request your information in order to *treat* you. Treatment begins with registering and admitting you for care with a Participant. Much of the information shared through eBHIN is for this registration and admission process. Treatment also means evaluating your condition, reaching a diagnosis, prescribing and providing health care services to address your diagnosis, and coordinating your care with other *Participants*.
- *Participants* may only share your information without your consent for *emergency treatment* of you.
- *Participants* all agree to request through eBHIN only the ***limited summary of my behavioral health record (listed above)***.
- Your health information is private and confidential and is protected by state and federal law. These laws relate to your health information generally, as well as mental and behavioral health information and alcohol and drug abuse treatment information. These laws are commonly referred to as HIPAA and 42 CFR Part 2. All *Participants* and eBHIN have signed agreements promising to protect your information as required by these laws.

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Patient Name: _____ **Other Name Used:** _____
Soc. Sec./4 digits _____ **Date of Birth:** _____

I consent to the disclosure of a **limited summary of my behavioral health record** which includes:

Demographic Information including name, date of birth, and Social Security Number	Emergency Contact Information	Substance Abuse History Summary
Diagnosis Information	Insurance Information	Trauma History Summary
Current Medications and Allergies	Employment Information	Mental Health Board Disposition
Living Situation and Social Supports	Billing Information	BryanLGH Emergency Dept. Chart

I consent to the following actions:

- _____ (“Agency”) may disclose a **limited summary of my behavioral health record** through eBHIN to any other eBHIN *Participant* which requests such information in order to treat me and has my consent.
- Any other *Participant* with confidential health information about me may disclose a limited summary of my behavioral health record through eBHIN to Agency for its use in treating me.
- Agency may incorporate the limited summary of my behavioral health record it receives through eBHIN into Agency’s own clinical record. From then on Agency may further disclose such information only in accordance with the rules that apply to it as a covered provider under HIPAA and 42 CFR Part 2.

I understand the limited summary may indicate the presence of a communicable or sexually transmitted disease, such as hepatitis, syphilis, gonorrhea, tuberculosis, and the human immunodeficiency virus (HIV), also known as Acquired Immune Deficiency Syndrome (AIDS). I expressly consent to the release of the limited summary through eBHIN, even when it indicates the presence of such a disease or condition.

Prohibition on Re-disclosure – Whenever a *Participant* requests records of an alcohol and drug abuse program through eBHIN, the disclosure will include a notice to the *Participant* that receives my information that re-disclosure is prohibited under federal law, except as permitted with my consent or when required by law. However, when the *Participant* incorporates alcohol and drug treatment information into its own clinical record about me, the prohibition may not apply. In such case the recipient will be governed by the state and federal rules applicable to that *Participant*.

Rights: I understand that the law gives me the following rights:

- I may **refuse to sign** this Consent. I understand that my refusal to sign this Consent will not prevent me from receiving care from Agency or another *Participant*.
- I may **revoke** this Consent. I understand that I may revoke this Consent in writing at any time except to the extent that Agency or a *Participant* has already relied on this form.
- I may **inspect** or copy my records. I understand that in almost all cases I have the right to inspect or copy the specific health information I have authorized to be disclosed by this Consent form.

Expiration Date – I understand that unless revoked sooner, this Consent expires in one year from the date I signed it or upon the following event: _____, whichever is sooner. Expiration or revocation means Agency will not provide any new confidential protected health information about you to eBHIN where it can be accessed by other *Participants*, unless and until you sign a new Consent form.

I acknowledge that I have received a copy of the document entitled, “What is the Consent to Release Health Information to eBHIN about?” and had an opportunity to ask questions. By signing this Consent form, I confirm that it accurately reflects my wishes.

Signature of Patient or Legal Representative

Date

Print Name

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