Empowered
ROSEMAN UNIVERSITY
COLLEGE OF MEDICINE

Note to EMPOWERED Program Personnel: *This consent form authorizes disclosures to a woman's other treating providers and health plans for treatment, payment or health care operations purposes only. Modifications to this consent form are required for disclosures for other purposes or to other entities.*

Patient's Name: _____ **Date of Birth:** _____

I understand that the purpose of the EMPOWERED program is to help reduce the risk and effects of neonatal abstinence syndrome (NAS) on my baby. By signing this form, I give permission for all of the individuals and organizations listed to share my substance use disorder information as described in this form:

1. **Who Can Share Your Substance Use Disorder Information.** I authorize the following health care providers to share my substance use disorder information:
   - EMPOWERED Program Personnel
   - Roseman University of Health Sciences

2. **Who Can Receive Your Information.**

   Please write in the name of the individual, the name of the health insurance plan, or the name of the treating provider organization that may receive your substance use disorder information from the parties in Section 1 above:

   ☐ Delivering Hospital: _____
   ☐ OB/High Risk OB: _____
   ☐ MAT Center: _____
   ☐ Health Insurance Plan: _____
   ☐ Pediatrician: _____
   ☐ Other: _____
   ☐ Other: _____
   ☐ Other: _____

3. **What kind of information.** Please select how much of your substance use disorder information should be shared with the individuals and organizations listed on this form:

   ☐ All of my substance use disorder information. This could include other sensitive information, such as communicable disease-related or HIV/AIDS-related information, behavioral health information, genetic testing information and developmental disabilities.

   If you do not want to share all of your substance use disorder information, please select the types of information you consent to share:

   ☐ Lab Results ☐ Pregnancy and delivery status ☐ Genetic testing information
   ☐ Medications ☐ Antenatal and post-partum ☐ Developmental Disabilities
   ☐ Progress Notes ☐ Communicable diseases (including HIV/AIDS)
   ☐ EMPOWERED Program records
   ☐ Other: _____

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4. **Dates of Information.** Please select whether any date restrictions apply to the substance use disorder information that you would like shared:

   ☐ **No date restrictions: Release all of my past, present and future substance use disorder information.**

   OR

   Only substance use disorder information for the following time period:

   _____ to _____

5. **Cooperative Sharing of Information.** By signing this form, I understand and acknowledge that the receipt of information from my other health care providers may be needed in order for the EMPOWERED Program to effectively provide me with services. To fully partake in the services provided by the EMPOWERED Program, I acknowledge and agree that I have authorized or plan to authorize the following of my health care providers to share substance use disorder information with Roseman University of Health Sciences and the EMPOWERED Program:

   ☐ Delivering Hospital: _____
   ☐ OB/High Risk OB: _____
   ☐ MAT Center: _____
   ☐ Health Insurance Plan: _____
   ☐ Pediatrician: _____
   ☐ Other: _____
   ☐ Other: _____
   ☐ Other: _____

6. **Purpose of the Disclosure.** Your substance use disorder information will be shared with the individuals and organizations listed on this form for care coordination and/or your treatment and the treatment of your baby, payment for that treatment (e.g.; billing insurance companies) and health care operations activities (e.g., improving the quality of care, managing care, patient safety activities, accreditation, peer review and other activities necessary to run a health care organization).

7. **Expiration Date.** I understand that I can revoke (take back) my consent at any time, except to the extent that the individuals or organizations listed on this form have already taken action in reliance on my consent. Unless I revoke my consent earlier, my consent will expire on: ____/____/____. If no date is entered, this consent will automatically terminate two years from the date of signature.

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I understand that my substance use disorder records are protected under the federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise permitted under those regulations and other applicable law.

I have been provided a copy of this form.

Signature of Patient: _____ **Date:** _____

Signature of Parent
(if Patient is a child)*: _____ **Date:** _____
The child and parent must both sign, unless the child consented to substance use disorder treatment without parental consent.

Signature of Patient's Legally
Authorized Representative*: _____ **Date:** _____
Applicable only if the patient is deceased or a court determines the patient is incompetent.

Witness: _____ **Date:** _____
EMPOWERED Program Personnel

Note to Recipient of Substance Use Disorder Information: *42 CFR part 2 prohibits unauthorized disclosure of these records.*

NOTICE OF PROHIBITION OF RE-DISCLOSURE

Date: _____
Re: _____
(Name of Patient)

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2).

The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed 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 (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.

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