CONSENT FOR THE DISCLOSURE OF CONFIDENTIAL SUBSTANCE USE INFORMATION

PRIVACY ACT STATEMENT

This statement serves to inform you of the purpose for collecting personal information as required by DD Form 3130, Consent for The Disclosure of Confidential Substance Use Information, and how the information will be used.

AUTHORITIES: Public Law 104-191, Health Insurance Portability and Accountability Act of 1996; 10 U.S.C., Chapter Ch. 55, Medical and Dental Care; 10 U.S.C. 1097a, TRICARE Prime: Automatic Enrollments; Payment Options; 10 U.S.C. 1097b, TRICARE Prime and TRICARE Program: Financial Management; 10 U.S.C. 1079, Contracts for Medical Care for Spouses and Children: Plans; 10 U.S.C. 1079a, TRICARE Program: Treatment of Refunds and Other Amounts Collected Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); 10 U.S.C. 1086, Contracts for Health Benefits for Certain Members, Former Members, and Their Dependents; 10 U.S.C. 1095, Health Care Services Incurred on behalf of Covered Beneficiaries: Collection From Third-party Payers; 42 U.S.C. 290dd, Substance Abuse Among Government and Other Employees; 42 U.S.C. 290dd-2, Confidentiality Of Records; 42 U.S.C 42 U.S.C. Ch. 117, Sections 11131-11152, Reporting of Information; 45 CFR 164, Security and Privacy; DoD 6025.18-R, DoD Health Information Privacy Regulation; and E.O. 9397 (SSN).

PURPOSE: To document a patient's authorization for third parties to release confidential substance use information necessary for the MHS to deliver comprehensive healthcare.

ROUTINE USES: Information collected by this form will be shared with third parties to document your authorization for those third parties to release your health information to the Military Health System (MHS)

Information in your records may also be disclosed to private physicians and Federal agencies, including the Departments of Veterans Affairs, Health and Human Services, and Homeland Security in connection with your medical care; other federal, state, and local government agencies to determine your eligibility for benefits and entitlements and for compliance with laws governing public health matters; and government and nongovernment third parties to recover the cost of healthcare provided to you by the Military Health System.

Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Rules, as implemented within DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

APPLICABLE SORN: EDHA 07, "Military Health Information System," (June 15, 2020, 85 FR 36190) **https://dpcld.defense.gov/Portals/49/Documents/Privacy/SORNs/DHA/EDHA-07.pdf**

DISCLOSURE: Voluntary. If you choose not to provide the requested information, third parties will be unable to release your health information to the MHS, which may result in the MHS being unable to provide comprehensive healthcare. However, care will not be denied.

SECTION I - PATIENT DATA

1. NAME: *(Last, First, Middle Initial)*	2. DATE OF BIRTH: *(YYYYMMDD)*	3. DoD ID/SSN: *(Use DoD ID unless necessary for security clearance investigation/verification or patient does not have a DoD ID)*

4. PERIOD OF TREATMENT: FROM - TO *(YYYYMMDD)*	5. TYPE OF TREATMENT: *(X One)*
	☐ OUTPATIENT ☐ INPATIENT ☐ BOTH

SECTION II - DISCLOSURE

6. I AUTHORIZE _____ TO RELEASE MY PATIENT INFORMATION TO:

(Name of Facility/TRICARE Health Plan / Providers)

a. NAME OF PERSON OR ORGANIZATION TO RECIEVE MY MEDICAL INFORMATION:	b. ADDRESS: *(Street, City, State, and ZIP Code)*
c. TELEPHONE: *(Include Area Code)*	d. FAX: *(Include Area Code)*

7. INFORMATION TO BE RELEASED: *(describe how much and what kind of information may be disclosed, including an explicit description of any substance use disorder information to be disclosed)*

SECTION III - RELEASE AUTHORIZATION

8. AUTHORIZATION. I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. parts 160 and 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 in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent will automatically expires in one year or upon written of revocation of the patient or client. I also understand that the written revocation must be in writing and provided to the facility where my medical records are kept or the TRICARE Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF. If not previously revoked, this consent will terminate on *(Specify date, event or condition)*:

a. START DATE: *(YYYYMMDD)*	b. EXPIRATION DATE: *(YYYYMMDD)*

c. TERMINATION EVENT OR CONDITION:

9. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE:	10. RELATIONSHIP TO PATIENT: *(If applicable)*	11. DATE: *(YYYYMMDD)*
12. NAME OF WITNESS: *(e.g. MHS Staff Member)*	13. SIGNATURE OF WITNESS	14. DATE: *(YYYYMMDD)*
15. NAME OF COMMANDER / DIRECTOR OR DESIGNATED OFFICIAL:	16. SIGNATURE	17. DATE: *(YYYYMMDD)*

REQUIRED NOTICE PROHIBITING REDISCLOSURE THAT NEEDS TO ACCOMPANY DISCLOSURES MADE WITH PATIENT CONSENT

This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (Title 42, Part 2, Code of Federal Regulations [42 C.F.R. 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 individual to whom it pertains or as otherwise permitted by 42 C.F.R. 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.

18. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE:	a. SPONSOR NAME:
	b. SPONSOR RANK:
	c. SPONSOR DoD ID:
	d. BRANCH OF SERVICE:
	d. TELEPHONE NUMBERS: