

FORM B – CONSENT FOR RELEASE OF PART 2 PROGRAM (SUBSTANCE USE DISORDER PROVIDER) INFORMATION

A Part 2 Program is a federally assisted: (i) individual or entity other than a general medical facility who holds itself out as providing, and provides, substance use disorder (SUD) diagnosis, treatment, or referral for treatment; (ii) an identified unit within a general medical facility that holds itself out as providing, and provides, SUD diagnosis, treatment, or referral for treatment; or, (iii) medical personnel or staff in a general medical facility whose primary function is provision of SUD diagnosis, treatment, or referral for treatment, and who are identified as such providers.

Section I					
First Name*	M.I.	Last Name*	Date of Birth* / /	Social Security Number	
Address			City	State	Zip Code
I hereby authorize the disclosure of health information about the above individual as follows.					
Section II					
<i>The information is to be disclosed by:</i>					
Name of Holder of Part 2 Program Information* University of Toledo Medical Center				Telephone Number 419-383-3668	
Address: 3000 Arlington Avenue		City Toledo	State OH	Zip Code 43614	
The information is to be provided to the following*:					
<input checked="" type="checkbox"/> Named Individual: RECORDS DEPOSITION SERVICE, INC.					
<input type="checkbox"/> Named Third Party Payer:					
<input type="checkbox"/> Named Treatment Provider Entity:					
<input type="checkbox"/> Named Non-Treatment Provider (such as an intermediary or research entity)*:					
<i>*If non-treatment provider is selected complete a, b and/or c below.</i>					
a. Named Individual Participant(s):					
b. Named Treatment Provider Entity Participant(s):					
c. Description of Group or Class of Treatment Provider Entity Participant(s):					
Contact Information (e.g. telephone number, email address, fax number, street address, etc.) PO BOX 5054, SOUTHFIELD, MI 48086-5054 P: 248-357-3330 F: 248-357-3337 E: INFO@RECDEP.COM					
Section III					
Reason for Disclosure*			Health information to be disclosed*:		
LEGAL - DISCOVERY BEFORE TRIAL					
Specify time period, if desired: Release only information from the period _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)					
Section IV					
This authorization will remain in effect until revoked or shall expire on date or event specified below. I understand that I may revoke or cancel this authorization at any time by submitting written revocation in the manner specified by the disclosing entity, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will expire on the date or completion of the event stated below. If no date or event is specified below, this authorization will expire in one year.					
Expiration Date or Event					
<ul style="list-style-type: none"> • Substance use disorder records of Part 2 programs disclosed pursuant to this Consent are protected by federal regulations and cannot be re-disclosed without my written consent unless otherwise provided for in the regulations. Any information disclosed pursuant to this Consent other than substance use disorder records or records protected under another state law may be subject to re-disclosure by the recipient. • I might be denied services if I refuse to authorize disclosure of information for purposes of assessment, treatment, or payment relating to substance use disorder if refusal is permitted by state law. My refusal to authorize disclosure of information for other purposes will not affect my ability to obtain treatment or services. • If I have authorized disclosure to a generally described group or class of participants in an entity which is not my treatment provider, upon my written request, I must be provided a list of entities to which my information has been disclosed pursuant to that general designation. 					
Signature of Individual or Authorized Representative* (identify relationship to individual below)				Date* (mm/dd/yyyy)	
Relationship of Authorized Representative to Individual (Authorized representative shall submit proof of authority to the disclosing entity)					
<input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Executor/Administrator <input checked="" type="checkbox"/> Other AGENT FOR ATTORNEY					
<input type="checkbox"/> I revoke this authorization. Signature: _____ Date: _____ Time: _____					
For administrative use only:					
Method of Delivery (e.g. paper, fax, electronic, oral, etc.) ELECTRONIC - INFO@RECDEP.COM				Date Released	