TPO Consent Form Instructions

The 42 CFR Part 2 is a federal regulation that protects the privacy of people receiving treatment for substance use disorders. It limits how their treatment records can be shared, even more strictly than Health Insurance Portability and Accountability Act (HIPAA) regulations, to reduce fear of stigma or legal consequences and encourage people to seek care.

The purpose of the patient consent form is to give written permission for a provider to share a patient's substance use treatment records with others, such as health plans or other care providers. Without this consent, most disclosures are not allowed. In addition, without this consent, insurance carriers may not pay for treatment.

What the consent covers
By signing, the patient agrees that their health information can be shared with:

- Treating providers
- Health plans and insurers
- Third-party payers and vendors

This includes details such as diagnoses, treatments, prescriptions and provider names. The information may be shared again as allowed by HIPAA but cannot be used in legal or government actions against the patient.

Expiration of consent

Consent Dates	
Validation Date	Expiration Date

Revoking consent
The patient can cancel this consent anytime by contacting the provider listed below. Canceling won't affect any actions already taken based on the original consent.

Important note
Once shared, the records may no longer be protected under the Substance Use Disorder Confidentiality Rule (Part 2), but they will still be protected under HIPAA.

If the patient does not sign:

- The provider may not be able to treat the patient
- The health plan may not pay for treatment

Sign and date
The patient (or someone legally allowed to sign for them) must sign and date the form. If someone else signs, include their relationship to the patient.

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TPO Consent for Disclosure of Part 2 Records

Patient Information

Patient First Name	Patient Middle Name	Patient Last Name
Health Plan ID Number	Date of Birth *(MM/DD/YYYY)*	
Address		
City	State	Zip Code
Phone Number	Email Address	

Person(s) Permitted to Make Disclosures

Provider Name		
Address		
City	State	Zip Code
Phone Number	Email Address	

Signature and Date

I have read the contents of this form. I agree to allow the disclosures of my information as described on page 1.

Patient Signature
Signature of person authorized to provide consent under 42 C.F.R. §§ 2.14 or 2.15, if applicable.
Relationship of person authorized to provide consent, if applicable.
Date *(MM/DD/YYYY)*

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