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| **DEPARTMENT OF HEALTH SERVICES**  Division of Care and Treatment Services  F-00397 (08/2016) | | |  | **STATE OF WISCONSIN** Federal Regulation  42CFR Part 2  Administrative Rule  DHS 75.15 (5) (i) | | |
| **CONSENT TO USE AND DISCLOSE INFORMATION FOR MULTIPLE REGISTRATION/CONTINUITY OF CARE** | | | | | | |
| Completion of this form is mandatory per 42 CFR § 2.34. Failure to complete and sign this form will result in the patient not being admitted for treatment in an opioid treatment program (OTP). | | | | | | |
| I, | Patient’s Name | do hereby authorize | | | Opioid Treatment Facility Name | |
| OTP to disclose information as required by 42 CFR § 2.34 and state regulations for the purpose of verifying my enrollment status at any other OTP. I approve the use within the Central Registry of the following information:   * My full legal name * Any alias I used within the last two years * The last four digits of my Social Security number * My sex * My birth date * My mother’s first name * My admission date to the OTP * My zip code of residence * My race * My ethnicity * The name of the medication I receive for treatment of opioid dependence/abuse * The form of the medication I receive for treatment of opioid dependence/abuse * The dosage of the medication I receive for treatment of opioid dependence/abuse * The date I most recently received medication from an OTP * My current status of active enrollment or discharged status and discharge date from an OTP * A digital image of my face * My treatment plan * Any other information specified by the Wisconsin Department of Health services pursuant to 2015 WI Act 262 | | | | | | |
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| I understand that the information above will be maintained by Lighthouse Software Systems, LLC (“LHSS”) Central Registry for purposes of my participation in opioid treatment within the state of State Name for the purposes of verifying my eligibility for care, reporting of aggregate data, and aiding my care in times of disaster or service disruption, which may include my crossing state lines to obtain treatment. In order to prevent enrollment in multiple OTPs my current patient status will be verified by the LHSS Central Registry in all states serviced by the LHSS Central Registry. I understand that my name will be encrypted within the LHSS Central Registry system database and that all my information will be protected in accordance to Health Insurance Portability and Accountability Act (HIPAA) standards. | | | | | | |
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| I approve use of the above-described information by any OTP that is licensed and in good standing where I present for treatment services. I further approve access to the above-described information by my state opioid treatment authority (SOTA), and their supporting staff, and other state agencies in times of disaster should I present for treatment across state lines. My information is to be used by OTPs and/or state agencies for the purpose of aiding me in times of disaster or service interruption, including emergency dosing and verifying my eligibility to receive medication away from my home OTP. | | | | | | |
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| I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and HIPAA, 45 CFR Parts 160 and 164. This consent will automatically expire 61 days after termination of treatment services or my discharge from the OTP. I understand that my information will remain in the LHSS Central Registry after my discharge but will not be shared with any OTP beyond the expiration date of this consent. | | | | | | |
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| This consent is subject to revocation at any time except to the extent that the program that is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate upon: | | | | | | |
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| **PATIENT NOTIFICATION:** | | | | | | |
| This treatment facility is required to notify each patient prior to admission that it cannot provide medication-assisted treatment to a patient who is currently and simultaneously receiving medication-assisted treatment at another OTP. | | | | | | |
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| **PATIENT STATEMENT:**  I am currently not receiving medication-assisted treatment from another OTP, and I further understand that if I do not sign this statement, I will not be admitted for treatment. | | | | | | |
| Patient Signature | | | | | | Date Signed |
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| Staff Witness Signature | | | | | | Date Signed |
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