IMPORTANT: Federal law (42 CFR Part 2) provides special confidentiality protections for substance use disorder (SUD) treatment records. These records CANNOT be disclosed without your written consent EXCEPT in certain limited circumstances. This consent is separate from your general HIPAA authorization.

PART A: PATIENT INFORMATION

Patient Full Name | Date of Birth | Medical Record # (if assigned)

PART B: WHO IS DISCLOSING INFORMATION

Program / Provider Name: Backcountry Mental Health
Address:
Email: support@backcountrymentalhealth.com

PART C: TO WHOM INFORMATION WILL BE DISCLOSED

Name of Individual / Organization | Phone / Fax

Address:

City | State | ZIP | Relationship to Patient

PART D: WHAT INFORMATION WILL BE DISCLOSED

Check all that apply:

- ☐ SUD diagnosis and treatment history
- ☐ SUD counseling records / progress notes (requires separate consent under updated Part 2 rules)
- ☐ Medication for opioid use disorder (MOUD) records (e.g., buprenorphine, methadone)
- ☐ Drug / alcohol screening results
- ☐ Referral information
- ☐ Discharge summary
- ☐ General summary of treatment for care coordination

Other (specify):

PART E: PURPOSE OF DISCLOSURE

- ☐ Care coordination / treatment by another provider
- ☐ Referral to another treatment program

- ☐ Insurance / billing purposes
- ☐ Legal / court purposes (specify below)
- ☐ Personal use by patient

Other purpose (specify):

PART F: EXPIRATION

This consent expires on: (check one)

- ☐ A specific date: _____
- ☐ Upon the occurrence of the following event: _____
- ☐ One (1) year from the date of my signature

Under the 2024 Final Rule (effective Feb. 16, 2026), a single consent may cover all future treatment, payment, and health care operations (TPO) disclosures. This does NOT include SUD counseling notes, which require a separate authorization.

PART G: YOUR RIGHTS AND IMPORTANT NOTICES

RIGHT TO REVOKE: You may revoke this consent at any time by submitting a written revocation to Backcountry Mental Health at support@backcountrymentalhealth.com. Revocation does not affect disclosures already made in good-faith reliance on this consent.

PROHIBITION ON RE-DISCLOSURE: The recipient of your SUD records may NOT re-disclose your SUD information to anyone else without your separate written consent, except as permitted by 42 CFR Part 2 (e.g., medical emergency).

CONSEQUENCES OF NOT SIGNING: Signing this form is voluntary. You will not be denied treatment for refusing to sign. However, some coordination of care activities may be limited if records cannot be shared.

MEDICAL EMERGENCY EXCEPTION: Even without consent, we may disclose your SUD records to medical personnel in a medical emergency that threatens your life.

PART H: SIGNATURE

I have read (or had read to me) this consent form and understand its contents. I voluntarily authorize the use and disclosure of my substance use disorder records as described above.

Patient Signature	Printed Name	Date
_____	_____	_____

If patient is a minor or lacks capacity to consent:

Authorized Representative Name	Relationship / Legal Authority

For Office Use Only:

Consent received by: _____ Date received: _____ Copy provided to patient: Y / N