AXIS Health System

Consent to Share Part 2 Information

Patient Information
Patient Name: _____ **Date of Birth**: _____
Phone/Email: _____

Consent to Share Part 2 Substance Use Disorder Records for Treatment

Authorized Recipient(s) and Purpose of Consent
I authorize Axis Health System to disclose my substance use disorder (SUD) treatment records to other healthcare providers, care teams, and organizations involved in my care for the purposes of treatment as defined under HIPAA.
Scope of Disclosure
This consent includes the sharing of my SUD records with: ▪ My healthcare providers ▪ Behavioral health professionals ▪ Care coordinators
Retroactive Disclosure Notice
I understand and agree that this consent applies to records created or received by Axis **on or after February 16, 2024**, including any records previously disclosed to integrated care partners, to the extent permitted by law.
Future Disclosure Notice
I understand this consent allows future disclosures of my SUD records for treatment purposes until I revoke this authorization in writing. I also understand that once disclosed, my records may be redisclosed by HIPAA-covered entities in accordance with HIPAA regulations.
Revocation and Expiration
I may revoke this consent at any time by submitting a written request to Axis's Health Information Management Department. This form automatically expires 2 years from the date signed, or when revoked (cancelled), or the expiration event as specified: _____.
Patient Acknowledgement
I understand that my SUD records are protected under federal law 42 CFR Part 2 and HIPAA, and that this consent enables coordination of care across my providers to support my health and recovery.

I understand:

- I am not required to sign this form to receive treatment, enrollment, or eligibility for benefits from Axis. If a court requires disclosure of my records as part of receiving services from Axis, I understand I will be required to complete a separate consent for release to the criminal justice system.
- I may request a copy of this form at any time, and a copy of this form is as valid as the original.
- Substance use program records protected by 42 CFR Part 2 may not be used or disclosed for civil, criminal, administrative, or legislative proceedings against me without my written consent or a court order.
- Records disclosed under this form may include information related to sexually transmitted diseases (STDs), acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV, behavioral or mental health services, and treatment of alcohol or drug use.
- **By signing below, I affirm I am allowed (have legal authority) to sign on my own or on behalf of the patient. I may be asked for documentation to verify my authority to sign this form.**

_____ _____

Signature of patient/legal guardian/personal representative Date

_____ _____

Printed name (if signing on behalf of patient) Relationship to patient (**required** if signing on behalf of patient)