VirginiaPremier™
Powered by VCU Health

Substance Use Disorder

Member Release of Confidential Information Consent Form

Name:		Medicaid ID:			
Phone:		DOB:			
Address:					
City:		State:		Zip Code:	

1. I hereby authorize Virginia Premier and/or their employees, agents, and representatives to disclose information they have received about my substance use disorder treatment. The information to be disclosed is identified below (check all that apply):

- □ Admission to the program
- □ Assessment and Diagnosis
- □ Compliance with treatment recommendations and referrals
- □ Progress towards accomplishing treatment plan goals and objectives
- □ Diagnostic lab work
- □ Program participation
- □ Financial documentation
- □ Treatment plan goals and objectives
- □ Substance use history summaries
- □ Alcohol and/or drug treatment records
- □ Mental health history summaries
- □ Other _____

2. I authorize the disclosure of the specified information above to (check all that apply):

- □ The following individual(s): _____ (Individual)
- □ The following treating provider(s): _____ (Entity)
- □ The following payor(s): _____ (Entity)
- □ "My treating providers."

I understand that if I have authorized disclosure to "my treating providers" above, I may request at any time that Virginia Premier provide me with a list of all such disclosures in the preceding two years, including the name of the individuals/entities to whom a disclosure was made, the date of disclosures, and a brief description of the identifying information disclosed. I understand my request must be made in writing, and that Virginia Premier will have 30 days to respond.

3. The release of information can be used for the following purpose(s) (check all that apply):

- □ Service/care coordination
- □ Substance use treatment activities
- □ Other _____

I understand that the disclosure will be limited to the extent necessary to carry out the above purpose.

I understand that my consent contained herein is subject to my revocation at any time except to the extent that Virginia Premier or other lawful holder of patient identifying information that is permitted to make the disclosure has already acted in reliance on it.

This consent will expire at the time specified below, after which time it will not be necessary to serve the purpose for which it was provided.

- □ Upon my disenrollment from Virginia Premier
- □ At the specified date: _____
- □ Other: _____

Signature:		Date:	
If the information you are requesting to be disclosed is not about you or your minor child, please complete the section below. If you are a legal representative of the person whose information you are requesting, you must provide documentation proving your legal authority to request this information (for example: power of attorney, guardianship papers, health care surrogate form, etc.).			
Legal Representative Signature:			
Legal Representative Printed Name:			
Relationship of Representative:		Date:	