BLUE SKY
COUNSELING

Consent for Use and Disclosure of Substance Use Disorder Information For Treatment, Payment, and Health Care Operations

Client Name:_____Date of Birth:_____Phone:_____

Street Address:_____City/State/Zip:_____

Purpose of This Consent
Federal law provides additional protections for records related to substance use disorder diagnosis, treatment, or referral for treatment. This form allows Blue Sky Counseling to use and disclose my substance use disorder information for Treatment, Payment, and Health Care Operations (TPO) as permitted by law.

What This Consent Allows
By signing below, I understand and authorize Blue Sky Counseling to use or disclose my substance use disorder information for the following purposes:

Treatment
- Coordination of care with other treating providers
- Communication with pharmacies, laboratories, hospitals, and specialists
- Clinical consultation and care planning

Payment
- Insurance billing, claims processing, and eligibility verification
- Collection of payment and benefits coordination

Health Care Operations
- Quality improvement and internal audits
- Licensing, accreditation, and compliance reviews
- Training and supervision of staff
- Care coordination systems and health information exchanges (when applicable)

Important Limitations
- This consent does not authorize disclosure to employers, schools, family members, courts, or marketing entities unless I sign a separate authorization naming those parties.
- This consent does not allow sale of my information.

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Redisclosure Notice
Federal law prohibits the recipient of substance use disorder information from redisclosing this information unless expressly permitted by my written consent or as otherwise allowed by law.

My Rights

- I understand this consent is voluntary.
- I may revoke this consent at any time in writing, except to the extent action has already been taken in reliance upon it.
- Revocation will not affect prior uses or disclosures made while this consent was in effect.

To Revoke:
Contact the Privacy Officer at Blue Sky Counseling
Phone: 207-616-0705
Email: jburnhamleavitt@blueskycounseling.com

Expiration
This consent will remain in effect until revoked in writing by me, or until my discharge from Blue Sky Counseling, whichever occurs first.

Signature
I have read and understand this consent. I have had the opportunity to ask questions.

Client Signature: _____ Date: _____

Printed Name: _____

Staff/Witness Signature: _____ Date: _____