Consent to Release Confidential Information

Section 1: What information am I agreeing to share?

This consent applies to the following information about me/the Patient listed below ("Covered Information"):

- Substance Use Disorder (SUD) treatment records maintained by healthcare providers or other entities, including Wayspring, who have treated the Patient (including, but not limited to, medications and dosages, lab test results, clinic visits, diagnostic information, discharge summary etc.); AND
- Claims data related to SUD treatment, which may include a summary of the Patient's diagnoses and services received; AND
- Information that may indicate that the Patient has or had a substance use disorder.

Section 2: Who may share this information with Wayspring?

Please select one of the options below:

☐ Option 1: I give permission for all of my past, current, or future treating providers and/or their facilities to disclose my Covered Information to Wayspring.

☐ Option 2: I give permission for these specific individual(s) or organization(s) to share my Covered Information.

Name of the individual(s) and/or healthcare organization(s) that I have (or had) a treating provider relationship:	Enter their contact information:			
	Phone	City	State	ZIP Code

Section 3: To whom may Wayspring disclose my Covered Information?

Wayspring may disclose my Covered Information to the following Providers for the purpose of providing services to me, including coordinating care and providing treatment:

☐ Option 1: "I give permission for all of my past, current, or future treating providers and/or their facilities to receive my Covered Information in connection with Wayspring services."

☐ Option 2: "I give permission for these specific individual(s) or organization(s) to receive my Covered Information."

Name of the individual(s) and/or healthcare organization(s) that I have (or had) a treating provider relationship:	Enter their contact information:			
	Phone	City	State	ZIP Code

Section 4: Family Members and Others Involved in Your Care

May Wayspring tell any of your family members or other people about your treatment information or the services (including sharing Covered Information)?

- ☐ **YES**
- ☐ **NO**

If you selected "Yes," who may we tell?
Approved family members (include name and phone number): _____

Relationship to patient: _____

Approved individual (include name and phone number): _____

Relationship to patient: _____

Approved individual (include name and phone number): _____

Relationship to patient: _____

May Wayspring tell your community-based resources, or other care team members about your Covered Information or the services (including sharing PHI)?

- ☐ **YES**
- ☐ **NO**

Section 5: How to stop the sharing of your information:

I understand that I can terminate or cancel my permission to share my Covered Information at any time by contacting Wayspring as follows.:

Wayspring OR compliance@wayspring.com
Attention: Compliance
209 10th Ave S #350
Nashville, TN 37203

When I terminate or cancel this consent, I understand that going forward, my information will no longer be shared. I understand that any information that may have already been shared before Wayspring was notified of my cancellation cannot be taken back.

Section 6: General Terms

This consent expires when I am no longer receiving care from Wayspring or enrolled with my health plan who is covering Axial's services.

Date

Signature of Patient or Patient's Legal Representative

Signer's Printed Name

If signed by Patient's Legal Representative, description of Legal Representative's relationship to Patient:

_____.