



Miller Care Group
3850 Shore Drive Suite 315
Indianapolis, IN 46254
Telephone: 317-429-0061
Fax Line: 317-222-1953

Consumer Rights and Responsibilities

I understand that my substance use disorder treatment records are protected under the federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act 1996 ("HIPAA"), 45 C.F. R. pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that if my treating providers disclose my substance use disorder treatment records pursuant to this consent, the recipient will be provided a notice of non-disclosure.

- I understand there are no limitations placed on history of illness with diagnostic and therapeutic information including HIV testing or disease, substance abuse, psychiatric care or mental health information and genetic testing.
- I agree to release my records via FAX machine. I accept the risk of mis-directed information via mis-dialed phone number and mis-directed information within the receiving facility/company. A photocopy of this authorization shall be accepted with the same authority as the original.
- I understand I have a right to request a list of treating providers who have received my substance use disorder information from Miller Care Group pursuant to 42 CFR Part 2.
- I also understand that I may revoke this consent, orally or in writing by contacting the Program Coordinator at MCG at 317-429-0061 at any time except to the extent that action has been taken in reliance on it. We are unable to take back any disclosures we have already made with your consent, and we are required to retain as records of the care we provided to you.
- If not already revoked, this consent will remain in effect. Upon request, I can inspect or obtain a copy of the information I am authorizing to be released.
- I understand that I may be denied services if I refuse to consent to a disclosure for purposes of my treatment or payment. I will not be denied services if I refuse to consent to a disclosure for other purposes.
- I understand that I am responsible to update the Program Coordinator with any changes or updates to this authorization.
- I understand that I have a right to refuse treatment.

Exception to 42 CFR Part 2 can be made under the following circumstances:

- No consent needed for disclosure to medical personnel to respond to a bona fide medical emergency.
- No consent needed for disclosure made under a Qualified Service Organization Agreement.
- No consent necessary for disclosure if pursuant to valid court order and subpoena.
- No consent necessary for disclosure for "audit and evaluation".

If I have any questions about disclosure of my private health information, I can contact the Program Coordinator 317-429-0061. I have received a copy of this authorization and consent form.

Signature/legal representative or guardian

Date and Time

Authority/Relationship of representative to patient (attach copy)