D-ATM PARTICIPATION RELEASE

CONSENT FOR THE RELEASE OF CONFIDENTIAL PERSONAL MEDICAL AND/OR HEALTH CARE INFORMATION

I, _____, authorize
(Name of patient)

_____,
(Name of Opioid Treatment Provider)

for purposes of my participation in the D-ATM System ("Digital Access To Medication") to disclose the following personal medical information to SAMHSA and its agents, exclusively for D-ATM System Administration:

- D-ATM System identified biometric finger scan minutiae (i.e. finger scan data points used in conjunction with a mathematical algorithm to correlate user and system held data)
- D-ATM System PIN used as redundant form of participant identification
- Presently prescribed medication(s) used for my treatment and my schedule of dosing records. This information will reside in the D-ATM system for a period no longer than 90 days.

Excluding the above information, I understand that no other personal information about me, or my treatment, will be kept in the D-ATM System.

The purpose of the disclosure authorized in this consent is to allow the necessary access to my individual opioid addiction treatment medication records such that this information may be maintained via the D-ATM System and in instances of disaster or other circumstances of OTP service disruption, this information can be shared via the D-ATM System to a requesting OTP in order to assist them in providing my continued and uninterrupted treatment.

I understand that my medical records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically when I leave treatment at (Name of Opioid Treatment Provider).

I am aware that my consent per the above is only required if I wish to participate in the D-ATM System, and that I am otherwise free to withhold my consent.

I have been provided a copy of this form. I acknowledge my receipt of said copy and my consent to the contents described above through my signature below.

Dated: _____ _____
Signature of patient

_____
Signature of responsible party if other than patient