



CONSENT FORM FOR DUAL ENROLLMENT PREVENTION CHECK

Alabama Department of Mental Health
100 N. Union Street
RSA Union Building
Post Office Box 301410
Montgomery, Alabama 36130-1410

As a part of Lighthouse/Alabama Central Registry, the Alabama Department of Mental Health participates in a statewide, multi-state system to prevent enrollment of a patient in more than one opioid treatment program at a time and duplicative prescriptions for SUD (Substance Use Disorder) care.

Please complete the following fields:

Patient's FULL Name (First, Middle Initial, Last): _____

Last 4 Digits of SSN: _____

Date of Birth: _____

Gender/Sex: MALE FEMALE

This authorization to release confidential information may be revoked by me, in writing, at any time except to the extent that action has already been taken. This authorization to release confidential information shall be effective only long enough to answer the purpose for which it is given, and no future confidential information will be released without an additional signed consent form as required by 45 CFR Parts 160 & 164 and 42 CFR Part 2.

By signing below, I authorize the release of the above information to _____ for the purpose of dual enrollment checks. I understand the purposes of the release of this information, and I understand I am providing consent to release the above confidential information under 42 CFR Part 2 and other applicable state and federal privacy/confidentiality laws.

Patient Signature

Date

Witness Signature

Date