CAPITAL PARTNERS IN CARE HEALTH INFORMATION EXCHANGE

SUBSTANCE USE DISORDER ATTESTATION FORM

SECTION 1: Does your organization provide ANY substance use disorder services?

☐ **No (Skip to Section 4 – Sign and Date)**

☐ **Yes (Continue to Section 2 of the form below)**

SECTION 2: Please complete the checklist below.

42 CFR Part 2 is a federal regulation that defines confidentiality and privacy standards for substance use disorder health information. These regulations cover any information about alcohol and drug abuse patients and apply to any individual, entity or unit that is federally assisted and holds themselves out as a provider of alcohol or drug abuse, diagnoses, treatment or referral for treatment. ***You may wish to consult your legal counsel as you complete this form as it is not meant as a stand-in for legal guidance.*** You can also find more information about 42 CFR Part II, including FAQs about who is covered by the regulations and what is meant by "holds itself out" at https://www.samhsa.gov/health-information-technology/laws-regulations-guidelines

****Please answer these questions even if only part of your organization may fall under the regulations.****

1) Federal assistance: Is your organization currently:

☐Yes ☐No Authorized, certified, licensed, or registered by the federal government?
☐Yes ☐No Receiving federal funds in any form, including funds that do not directly pay for substance use disorder services?
☐Yes ☐No Granted tax-exempt status by the IRS?
☐Yes ☐No Allowed tax deductions for contributions by the IRS?
☐Yes ☐No Authorized to conduct business by the federal government, including programs?
☐Yes ☐No Certified as a Medicare provider?
☐Yes ☐No Authorized to conduct methadone maintenance treatment?
☐Yes ☐No Registered with the DEA, and use such license to the extent of treating substance use disorders?
☐Yes ☐No Conducting business directly by the federal government?

AND

2) Holds itself out as a provider of alcohol or drug abuse diagnoses, treatment, or referral for treatment as:

Do you currently hold yourself out as provider of alcohol or drug abuse treatment, diagnosis, or referral for treatment as:

☐Yes ☐No An individual or entity (other than a general medical care facility)?
☐Yes ☐No An identified unit within a general medical facility?
☐Yes ☐No Medical personnel or other staff in a general medical care facility whose primary function is the provision of alcohol or drug abuse diagnosis, treatment or referral for treatment?

If you checked AT LEAST ONE "Yes" response in BOTH categories above, you ARE likely subject to 42 CFR part 2 regulations.

SECTION 3: Please CHECK ONE attestation option below.

☐ **Option 1:** *By signing below, I, as the Privacy and/or Security Officer or appropriate surrogate, attest that all or part of our organization* ***IS NOT*** ***a federally assisted substance abuse program providing services under 42 CFR Part 2 Regulations.***

☐ **Option 2**: *By signing below, I, as the Privacy and/or Security Officer or appropriate surrogate, attest that all or part of our organization* ***IS*** ***a federally assisted substance abuse program providing services under 42 CFR Part 2, and my organization takes effective technological and administrative steps to block transmitting any clinical information (e.g. CCDs) to the DC HIE that relates to drug and alcohol treatment provided to an individual or any non-clinical information (e.g. a patient list) that directly or indirectly identifies an individual as having received services in the unit of your facility or from a provider in your facility that provides drug and alcohol diagnosis, treatment or referral for treatment.***

☐ **Option 3:** *By signing below, I, as the Privacy and/or Security Officer or appropriate surrogate, attest that all or part of our organization* ***IS*** ***a federally assisted substance abuse program providing services under 42 CFR Part 2 and, as such, may transmit certain patient information related to drug or alcohol treatment. Therefore, we agree to enter into a qualified service organization agreement (QSOA) with the DC HIE to identify the 42 CFR Part 2 covered entity or unit and covered information that will be shared under the QSOA and agree to share no additional information from the covered entity or unit without prior agreement.***

To be completed only if Option 3 was chosen:
Applicable Program/Provider/Location/Department(s) and 42 CFR Part II covered information that will be provided to the DC HIE. Organization may only provide covered information listed on this form unless the DC HIE gives prior consent to additional data disclosure. List participant organization again if fully federally assisted substance abuse program under 42 CFR part 2. Attach extra pages if needed:

Organization/Department/Practice Location/Program	Address	Covered Information to be Shared with the DC HIE (If Option 2 was chosen, this section should be blank)
EXAMPLE: XYZ Recovery Program	123 Main St., Washington, DC 12345	Patient Panel

SECTION 4: Please sign and date below.

Participating Organization:
Name:
Signature:
Date:
Email Address:

If you attested that you are a 42 CFR part 2 entity, subject to relevant regulations, and will be sending covered data to the DC HIE (Option 3 above), please review and sign the Participation Addendum/Qualified Service Organization Agreement (QSOA). (This document will be provided by the DC HIE.)