



Consent for Release of Confidential Information

Serving: Anchorage, Atka, Nikolski, Saint George, Unalaska

Name: _____ DOB: _____

Address: _____
Street or PO Box City State Zip Code

Telephone: _____ Parent/Legal Guardian: _____

I grant permission for: Aleutian Pribilof Islands Association, Inc., Behavioral Health
1131 E. International Airport Rd., Anchorage, AK 99518
Main: 907-276-2700 Fax: 907-279-4351

Atka Health Clinic Anchorage Behavioral Health Nikolski Health Center Saint George Health Center
 Oonalaska Wellness Center (primary care) Oonalaska Wellness Center (behavioral health)

To (check all that apply):

Release Information to Obtain information from
 Verbally In writing and/or electronically

Name: _____ Agency: _____

Address: _____ Telephone: _____
Street or PO Box City State Zip

Regarding the following information (CLIENT INITIAL all that apply):

Assessment, including diagnosis & treatment recommendations (Sub Use Only, MH Only, Integrated)	Psychiatric Evaluations or Psychological Assessments
Admission Summary	Treatment Status or progress in treatment
Results of Urinalysis and/or alcohol breathalyzer	Discharge Date and Summary
Attendance / Compliance	BH Medication Needs
Treatment Plan	Other (please specify):

For the following purposes (CHECK all that apply):

Referral/Treatment Placement follow-up	Coordination of services or care
Provide referral information	Other (please specify):
Verify participation in treatment	Other (please specify):

I understand that my alcohol and/or drug treatment records are protected under 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. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it (any information that has already been released cannot be recalled). I understand a release of information is not required under the following conditions: 1) court order 2) harm to self 3) harm to others.

This consent will expire one year from date signed or on: _____

I have received / declined a copy of this form.

Client or Legal Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

To the Recipient of Confidential Information

This information has been disclosed to you from records protected by Federal Confidentiality rules (42 CFR Part 2). The Federal Rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient.