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: 907-222-4279

☐ 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 laws governing the confidentiality of substance use disorder records (42 C.F.R. Part 2) and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and cannot be disclosed without my written consent unless otherwise provided for by the regulations. Treatment and benefits will not be contingent on signing this ROI, except to the extent that an ROI is necessary under 42 CFR Part 2 for payment purposes. **I also understand that I may revoke this consent orally, pursuant to 42 C.F.R. Part 2, or 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). This consent will expire one year from date signed or on:_____ whichever is earlier.

_____I have received / declined a copy of this form.

Client or Legal Guardian Signature: _____Date: _____

Witness Signature: _____Date: _____

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☐ **(Check if Substance Use Information is Included)**

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.