

Alaska Behavioral Health

Formerly Anchorage Community Mental Health Services, Inc. /Fairbanks Community Mental Health Services, LLC.

Authorization to Release Health Information

- Folker – Main Center - Adult Services | 4020 Folker Street Anchorage, AK 99508 | Ph. 907.563.1000 Fax 907.375.3115
 Family Services – On Target - PLL – AK Child Trauma Ctr – Little Tykes - AYA | 4045 Lake Otis Pkwy STE 101 | Anchorage, AK 99501 | Ph. 907.561.0954 Fax 907.375.3115
 Ingra Adult Services – IDP – Housing & Engaging Svcs. |1432 Ingra Street | Anchorage, AK 99501 | Ph. 907.562.7900 Fax 907.375.3115
 Fairbanks Adult Services |1423 Peger Road | Fairbanks, AK 99709 | Ph. 907.371.1300 Fax 907.371.1386
 Fairbanks Children's & Family Services | 926 Aspen Street | Fairbanks, AK 99709 | Ph.907.371.1300 | Fax.907.371.1387

Name _____ DOB: _____ SSN: _____
(Name of client whose information is being released) (Optional)

Previous Name(s) _____
(List any and all)

I, ____ Client ____ Parent ____ Legal Guardian hereby authorize

Release Information To: Obtain Information From:

Name: _____ Phone# _____

Address: _____ Fax# _____

The following information: written verbal

PURPOSE OF INFORMATION (Include client/parent/guardian initials)	INFORMATION TO BE RELEASED / REQUESTED
<input type="checkbox"/> Treatment Planning	<input type="checkbox"/> Admissions/Intake Summary
<input type="checkbox"/> Continued Treatment	<input type="checkbox"/> Discharge Summary
<input type="checkbox"/> Coordinate Treatment	<input type="checkbox"/> Treatment/Safety Plan
<input type="checkbox"/> Benefits/Supports	<input type="checkbox"/> Psychiatric Evaluation
<input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Medical Progress Notes
	<input type="checkbox"/> Clinical Progress Notes
	<input type="checkbox"/> Case Management Notes
	<input type="checkbox"/> Lab Results
	<input type="checkbox"/> Substance abuse Tx
	<input type="checkbox"/> Medication Records
	<input type="checkbox"/> Videography
	<input type="checkbox"/> Other (Specify) _____
	Date Range _____ to _____

- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I understand that I may inspect or copy the information to be used or disclosed, as provided in 45CFR 164.524, 42CFR Part 2.
- I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.
- I understand that the information released may include information regarding Psychiatric Treatment, Substance Abuse Treatment and/or HIV. If I have questions about disclosure of my health information, I can contact Alaska Behavioral Health Clinical Records at 563.1000.
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Alaska Behavioral Health Clinical Records at 563.1000.
- I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- I understand and agree to pay the costs incurred by Alaska Behavioral Health in preparing a copy of records I may request for myself as allowed by State and Federal guidelines.

By initialing this section, I am allowing the information to be disclosed one time. This authorization will expire 90 days from the date of my signature, unless otherwise indicated or revoked.

Unless otherwise indicated or revoked this authorization will expire 1 year from my signature date or in: _____ days. (must be less than 12 months)

Client Signature (Required for ANY substance use release) _____ Date _____

Relative/Guardian/Authorized Person _____ Printed Name _____ Relationship to Client _____ Date _____

Witness _____ Date _____

Copy must be offered to client: ____ Accepted ____ Refused

SERVICE PROVIDER TO COMPLETE THIS SECTION			
ACTION TO BE TAKEN:			
<input type="checkbox"/> Send For Records	<input type="checkbox"/> Send ROI Only	<input type="checkbox"/> Release Alaska Behavioral Health Records	<input type="checkbox"/> File ROI Only

Emergency Contact - Authorization to Release Health Information

- Folker – Main Center - Adult Services | 4020 Folker Street Anchorage, AK 99508 | Ph. 907.563.1000 Fax 907.375.3115
- Day Break Adult Care Services | 9210 Jupiter Drive | Anchorage, AK 99507 | Ph. 907.346.2234 Fax 907.375.3115
- Family Services – On Target - PLL – AK Child Trauma Ctr – Little Tykes - AYA | 4045 Lake Otis Pkwy STE 101 | Anchorage, AK 99501 | Ph. 907.561.0954 Fax 907.375.3115
- Ingra Adult Services – IDP – Housing & Engaging Svcs. |1432 Ingra Street | Anchorage, AK 99501 | Ph. 907.562.7900 Fax 907.375.3115
- Fairbanks Adult Services |1423 Peger Road | Fairbanks, AK 99709 | Ph. 907.371.1300 Fax 907.371.1386
- Fairbanks Children’s & Family Services | 926 Aspen Street | Fairbanks, AK 99709 | Ph.907.371.1300 | Fax.907.371.1387

Name _____ **DOB:** _____ **SSN:** _____
(Name of client whose information is being released) (Optional)

Previous Name(s) _____
(List any and all)

I, ___ Client ___ Parent ___ Legal Guardian hereby authorize

Release Information To: **Obtain Information From:**

Emergency Contact Name: _____ **Phone Number:** _____ **Decline Emergency Contact**

Address: _____

The following information: **written** **verbal**

PURPOSE OF INFORMATION (Include client/parent/guardian initials) <input type="checkbox"/> ___ Continued Treatment <input type="checkbox"/> ___ Legal Use <input type="checkbox"/> ___ Coordinate Treatment <input type="checkbox"/> ___ Other (Specify) _____	INFORMATION TO BE RELEASED / REQUESTED <input type="checkbox"/> Minimum Necessary <input type="checkbox"/> Other (Specify) _____
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- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I understand that I may inspect or copy the information to be used or disclosed, as provided in 45CFR 164.524, 42CFR Part 2.
- I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.
- I understand that the information released may include information regarding Psychiatric Treatment, Substance Abuse Treatment and/or HIV. If I have questions about disclosure of my health information, I can contact Alaska Behavioral Health Clinical Records at 563.1000.
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Alaska Behavioral Health Clinical Records at 563.1000.
- I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- I understand and agree to pay the costs incurred by Alaska Behavioral Health in preparing a copy of records I may request for myself as allowed by State and Federal guidelines.

By initialing this section I am allowing the information to be disclosed one time. This authorization will expire 90 days from the date of my signature, unless otherwise indicated or revoked.

Unless otherwise indicated or revoked this authorization will expire 1 year from my signature date or in: _____ days. (must be less than 12 months)

Client Signature (Optional for Minors/Adults with Guardians) _____
Date

Relative/Guardian/Authorized Person _____
Date

Printed Name _____
Relationship to Client

Witness _____
Date

Copy must be offered to client: ___ Accepted ___ Refused

SERVICE PROVIDER TO COMPLETE THIS SECTION			
ACTION TO BE TAKEN:			
<input type="checkbox"/> Send For Records	<input type="checkbox"/> Send ROI Only	<input type="checkbox"/> Release Alaska Behavioral Health Records	<input type="checkbox"/> File ROI Only