

ALASKA BEHAVIORAL HEALTH



CONSENT FOR SERVICES

Name of Client: _____ Client # _____

I, _____ (or _____)
Name of Client Authorized representative acting on behalf of client

request and voluntarily consent to receive mental health services from Alaska Behavioral Health (Organization). and its mental health staff. Such care may include routine diagnostic procedures and/or related services that the mental health staff may recommend as medically necessary. No guarantees have been made to me by the Organization as to the result of services or evaluation.

I understand that as part of my healthcare, this Organization originates and maintains health records that are used for Treatment, Payment and Health Care Operations.

With your permission we may ask to record your session to provide quality feedback, supervision to your clinician and to improve overall quality of our care to you. This recording is kept in a secure location until it has been reviewed by a supervisor and then it is stored in a secure location. I understand that my session with my therapist after obtaining my permission may be recorded for quality purposes.

CCBHC Consent for Data Collection

Because you are receiving services at Alaska Behavioral Health and we are a Certified Community Behavioral Health Center (CCBHC), you can participate in an effort to collect information that will help us better serve our community. **The data we provide to the Substance Abuse and Mental Health Services Administration (SAMHSA) is not individually identifiable by them.**

This form provides information so you can make an informed decision about your participation. Please read this form carefully and ask questions if you have them.

What is the purpose of the data collection?

Alaska Behavioral Health is partially funded by the United States Department of Health and Social Services/Substance Abuse and Mental Health Services Administration (SAMHSA). As part of this funding, SAMHSA requires Alaska Behavioral Health to collect and report information on all individuals served at our Organization to evaluate program effectiveness. If you choose to participate, the information you provide will help us improve our services.

What Information will I be asked to provide?

If you agree to participate, we will collect information in a face-to-face structured interview with you when you begin receiving services, every six months you remain in services, and when you leave services. The structured interview will use the SAMHSA National Outcome Measures (NOMs), Client-level Measures for Discretionary Service Programs Providing Direct Services Tool, child or adult version.

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Demographic information will be obtained at the first interview including gender, ethnicity, race, and month and year of birth. At each interview, participants will be asked questions regarding:

- Functioning
- Military Family and Deployment
- Substance Use
- Violence and Trauma
- Housing
- Education
- Crime and Criminal Justice
- Perception of Care
- Social Connectedness

How will my privacy be protected?

Information collected by Alaska Behavioral Health staff during the structured interview will be entered into a **secured** SAMHSA database called Performance Accountability & Reporting System (SPARS). SPARS is a password protected, web-based system for reporting information on SAMHSA funded programs. Your name will not be provided to SAMHSA. Instead, your information will be identified with a number assigned by Alaska Behavioral Health staff. This number does not include any part of your name, date of birth or social security number. This ID number is designed to track a specific recipient through his/her interview(s) while maintaining anonymity.

How will the information be used?

The primary purpose of data collection is to improve services at Alaska Behavioral Health. Your clinician will review the results with you to help plan ongoing services. Additionally, your responses will be used to determine the effectiveness of services at Alaska Behavioral Health. The results of clinic-wide analyses may be used to report about program services.

SAMHSA uses aggregate data to conduct performance evaluation of federally funded programs. Aggregate data refers to de-identified information that is collected from multiple sources and combined into summary reports, typically for the purpose of public reporting or statistical analysis. With aggregate data sets, it is not possible to identify the information that has been provided by any given respondent.

What are the potential risks of my participation?

The primary risks of participation include potential discomfort with answering questions about sensitive issues and the possibility that someone you have not authorized could gain access to your protected health

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information. With respect to the first risk, Alaska Behavioral Health makes every effort to provide a safe and supportive therapeutic environment. Your clinician will be available to provide assistance and has been trained in ways to discuss sensitive and personal information. Additionally, if you choose to participate, you have the right to refuse to answer any question(s). With respect to the second risk, Alaska Behavioral Health has strict policies and procedures in place to comply with state and federal laws protecting the confidentiality of health information and substance use. Additionally, your information is not able to be individually identified by SAMHSA, rather the information is assessed as a whole.

What are the potential benefits of my participation?

Your participation will help Alaska Behavioral Health improve services for individuals and families in our community. It will also provide you with important information about your well-being that will facilitate treatment and discharge planning.

Your participation is voluntary:

Your participation in the evaluation is voluntary. If you decide not to participate in the data gathering, you will not be denied services and treatment will not be affected. Additionally, if you and/or your child choose to participate, you are free to withdraw your consent/assent and discontinue participation at any time without this decision affecting your care and treatment with Alaska Behavioral Health.

What if I have questions?

You will receive a copy of this consent/assent form for your records. If you have questions about the evaluation you can discuss these with your clinician or Pamela Kennedy, Privacy Officer for Alaska Behavioral Health. They will be happy to answer your questions or discuss any concerns.

Privacy Officer:

Pamela Kennedy, LPC-S, CHPC
Director of Quality
(907) 561-1000

Consent

I have been allowed the opportunity to ask questions concerning any and all aspects of this evaluation and the procedures involved. I understand that the evaluators and the program staff have set up procedures to protect the confidentiality of records related to my involvement. I consent to the use and disclosure of my records by Alaska Behavioral Health as described above, and to the disclosure of information to SPARS and SAMHSA. I understand that I can choose not to participate in data gathering or revoke consent at any time, and that if I do so I will not be denied services or benefits.

I understand that my alcohol and/or drug treatment/rehabilitation records (if any) are protected under the Health Insurance Portability Accountability Act of 1996 (HIPAA), and its enacting regulations, and that, depending on the nature of the record and treatment involved, my records may also be protected under the federal regulations governing confidentiality of substance use disorder patient records, 42 C.F.R. Part 2. I understand that only health information covered by 42 C.F.R. Part 2 (i.e., alcohol and drug use or treatment) will continue to be protected by law from redisclosure once it leaves Alaska Behavioral Health. However, if

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the information is covered only by HIPAA, it is subject to redisclosure by the recipient and may no longer be protected. I understand that my records that are subject to HIPAA cannot be disclosed beyond what is permitted under this consent, unless otherwise permitted by law.

This consent shall not expire until six (6) months after I complete services with Alaska Behavioral Health, or until I revoke this consent, whichever occurs earlier. **If I revoke this authorization, I must do so in writing and present my written revocation to Alaska Behavioral Health for general medical records, and in writing or orally for substance use disorder treatment records.** This revocation will not apply to information that has already been released in response to this authorization.

My signature below indicates my agreement to engage in behavioral health services at Alaska Behavioral Health and reflects my decision to participate in the CCBHC data collection process.

SIGNATURE OF CLIENT

DATE

WITNESS

DATE

(Adults) SIGNATURE OF **RELATIVE/GUARDIAN**
Or **AUTHORIZED REPRESENTATIVE**

DATE

MINOR CLIENTS ONLY: Are you the parent or guardian to the minor client? YES NO

If "YES" to above question, please provide **Photo ID to reception.**

If you are signing as the caregiver for the minor client: I acknowledge I am signing as the caregiver for this minor. I attest that the parent/legal guardian is not available to sign for needed medical services at the Organization despite attempts to engage the relative or legal guardian.

SIGNATURE OF AUTHORIZED REPRESENTATIVE

DATE

Printed Name and Relationship to Client: _____

STAFF only: Document(s) obtained (circle one): Legal Documentation of Guardianship; Unable to reach Guardian; Unable to produce documentation

Staff Completed:
Client Name:
Client ID:

CLIENT INFORMATION

AKAIMS MDS ~ Staff to complete if client is unable.

Client Profile

- Name (First and Last):** _____
- Maiden Name:** _____
- Alternate/ Other Names you are known by: _____
- Client Gender (circle response):**
 Male Female
 Female Becoming Male Female Formerly Male
 Male Becoming Female Male Formerly Female
 No Response Unknown
- Date of Birth (mm/dd/yyyy): ___ / ___ / _____
- Social Security Number: ___ - __ - ____
- Medicaid ID Number:** _____
- Current Mailing Address: (Ok to send mail) _____
- Current Physical Address: _____
- Phone Number(s):
 HOME: _____ Primary Would you like to receive text
 MOBILE: _____ Primary or automated reminder calls? Yes No
- Where Were You Born? _____
- Are You a U.S. Citizen (circle response): Yes No
 Please circle: Can you: Speak - Read - Write in the English language? Yes No Do you need an interpreter? Yes No
- What language do you prefer to speak? _____
- Do you have a Legal Guardian? If yes, Name: _____
 Address: _____
- Emergency Contact/Alternate Contact Name: _____
 Phone Number(s): (ok to call) _____
- Religious Preference: _____ No Response

Demographics (Additional Information)

<u>Race(s): Check all that apply</u> <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other _____ Alaska Native <input type="checkbox"/> Aleut <input type="checkbox"/> Athabascan <input type="checkbox"/> Haida <input type="checkbox"/> Inupiat <input type="checkbox"/> Tlingit <input type="checkbox"/> Tsimshian <input type="checkbox"/> Yupik <input type="checkbox"/> Other _____	<u>Ethnicity: Check one</u> <input type="checkbox"/> Not Spanish/Hispanic/Latino <input type="checkbox"/> Chicano/Other Hispanic <input type="checkbox"/> Cuban <input type="checkbox"/> Hispanic <input type="checkbox"/> Mexican American <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Spanish/Hispanic/Latino <u>Annual Household Income: Check One</u> <input type="checkbox"/> 0-\$999 <input type="checkbox"/> \$1,000-4,999 <input type="checkbox"/> \$5,000-9,999 <input type="checkbox"/> \$10,000-19,999 <input type="checkbox"/> \$20,000-29,999 <input type="checkbox"/> \$30,000-39,999 <input type="checkbox"/> \$40,000-49,999 <input type="checkbox"/> \$50,000 and over	<u>Education: Check one</u> <input type="checkbox"/> No Schooling <input type="checkbox"/> If K-11, how many years _____ <input type="checkbox"/> GED <input type="checkbox"/> High School Diploma <input type="checkbox"/> Vocational Training <input type="checkbox"/> Special Ed Ungraded Classes <input type="checkbox"/> Bachelor's degree (BA, BS) <input type="checkbox"/> Graduate work (no degree) <input type="checkbox"/> Master's degree <input type="checkbox"/> Doctorate/ Professional degree <input type="checkbox"/> Post-Secondary 1 yr <input type="checkbox"/> Post-Secondary 2 yrs (Inc. AA degree) <input type="checkbox"/> Post-Secondary 3 yr <input type="checkbox"/> Post-Secondary 4+ yrs (no degree) <input type="checkbox"/> Other _____
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For Staff Use Only:
 Clinician/Staff Initials: _____
 Data Entry Initials: _____

Client Last Name, First Initial: _____
 Client ACMHS Number: _____
 Last updated 7/13/13, 4/5/17, 1/18/19

CLIENT INFORMATION

AKAIMS MDS ~ Staff to complete if client is unable.

Veteran Status: Check one

- | | |
|--|---|
| <input type="checkbox"/> Retired from military; non-combat
<input type="checkbox"/> Never in Military
<input type="checkbox"/> Vietnam Era Veteran; combat
<input type="checkbox"/> Vietnam Era Veteran; non-combat
<input type="checkbox"/> Gulf War Veteran; Combat
<input type="checkbox"/> Iraq War Veteran; Combat
<input type="checkbox"/> Afghan War; Combat
<input type="checkbox"/> In Reserves/Nat. Guard; combat
<input type="checkbox"/> In Reserves/Nat. Guard; non-combat
<input type="checkbox"/> Military Dependent | <input type="checkbox"/> On Active duty; combat
<input type="checkbox"/> On Active duty; non-combat
<input type="checkbox"/> Retired from military; combat
<input type="checkbox"/> Separated, Non-Combat, Honorable Discharge
<input type="checkbox"/> Separated, Non-Combat, Other Than Honorable Discharge
<input type="checkbox"/> Unknown
<input type="checkbox"/> Veteran other eras
<input type="checkbox"/> Not Applicable |
|--|---|

Health and Treatment Information (Admission Profile)

1. **Have you ever been in the hospital or residential treatment for substance abuse?** ___ Yes ___ No
 If Yes, how many times? _____
2. **Have you been in the hospital in the last 6 months for medical problems caused by substance abuse?**
 ___ Yes ___ No If Yes, how many times? _____
3. **How many inpatient mental health hospitalizations have you had?** _____
4. **Only required if FEMALE:** Pregnant: ___ Yes ___ No ___ Unknown **If Yes,** due date: ___/___/___
5. **Injection Drug User:** ___ Yes or ___ No

Financial Information (Admission)

Employment Status: Check One

- Disabled
- Employed Full Time
- Employed Part Time
- Homemaker
- In the Armed Forces
- Not in Labor Force/Other
- Not Seeking Work
- Resident/Inmate
- Retired
- Seasonal Employee/in season
- Seasonal Employee/out season
- Student
- Unemployed/Not seeking work
- Unemployed/Subsistence
- Unemployed/Looking for work
- Other _____
- No Response

Primary Income Source: Check One

- Tribal Assistance Program
- None
- Alaska Native Corp Dividends
- Alimony
- Alaska PFD
- Child Support
- Employment
- Interest & Other
- Public Assistance/ Welfare Pay
- Parent's Income
- Railroad Retirement
- Retirement/Survivor/Disability Pension
- Social Security Disability (SSDI)
- Self-Employment
- Supplemental Security Inc (SSI)
- Spouse/Significant Other's Income
- Social Security
- Unemployment Compensation
- Other

For Staff Use Only:

Clinician/Staff Initials: _____
 Data Entry Initials: _____

Client Last Name, First Initial: _____
 Client ACMHS Number: _____
 Last updated 7/13/13, 4/5/17, 1/18/19

CLIENT INFORMATION

AKAIMS MDS ~ Staff to complete if client is unable.

Admission ~ Financial Info Screen

<p><u>Expected Payment Source: Check One</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Aetna <input type="checkbox"/> AK Native Health Care <input type="checkbox"/> Blue Cross/Blue Shield <input type="checkbox"/> CIGNA <input type="checkbox"/> Client Self Pay <input type="checkbox"/> HMO <input type="checkbox"/> Indian Health Services <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> MODA Health <input type="checkbox"/> No charge <input type="checkbox"/> Other Government Grant <input type="checkbox"/> Other Native Health Care <input type="checkbox"/> Other Private <input type="checkbox"/> Other Public <input type="checkbox"/> Sliding Scale, Client Partial Payment <input type="checkbox"/> Sliding Scale, No Charge <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown 	<p><u>Insurance Type: Check One</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Indian Health Services <input type="checkbox"/> None <input type="checkbox"/> Commercial <input type="checkbox"/> Medicare Conditionally Primary <input type="checkbox"/> Group Policy <input type="checkbox"/> HMO <input type="checkbox"/> Individual Policy <input type="checkbox"/> Long Term Policy <input type="checkbox"/> Litigation 	<ul style="list-style-type: none"> <input type="checkbox"/> Medicare Part B <input type="checkbox"/> Medicaid <input type="checkbox"/> Medigap Part B <input type="checkbox"/> Medicare Primary <input type="checkbox"/> Other Public Insurance <input type="checkbox"/> Other Private Insurance <input type="checkbox"/> Personal Payment (Cash-No Insurance) <input type="checkbox"/> Supplemental Policy <input type="checkbox"/> VA insurance <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown
<p><u>Living Arrangement: Check One</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Correction/Detention Facility <input type="checkbox"/> Crisis Residence <input type="checkbox"/> Foster Care <input type="checkbox"/> Group Home <input type="checkbox"/> Halfway House <input type="checkbox"/> Homeless <input type="checkbox"/> Hospital for Non-Psychiatric Purposes <input type="checkbox"/> Hospital for Psychiatric Purposes 	<ul style="list-style-type: none"> <input type="checkbox"/> Nursing home <input type="checkbox"/> Private Residence w/out supportive services <input type="checkbox"/> Private residence w/supportive services <input type="checkbox"/> Residential Treatment <input type="checkbox"/> Shelter <input type="checkbox"/> Therapeutic Foster Care <input type="checkbox"/> Transitional Housing <input type="checkbox"/> Other _____ <input type="checkbox"/> No Response <input type="checkbox"/> Unknown 	<p><u>Marital Status: Check one</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Cohabiting <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Never Married-Single <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> No Response <input type="checkbox"/> Not Collected <input type="checkbox"/> Unknown
<p><u>Living in Home: Answer both</u></p> <p>1. Number of people that live with you: _____</p> <p>2. Number of children in the household: _____</p>		

Admission ~ Legal History Screen

Number of Arrests: In the **past 30 days (required)** _____

For Staff Use Only:
 Clinician/Staff Initials: _____
 Data Entry Initials: _____

Client Last Name, First Initial: _____
 Client ACMHS Number: _____
 Last updated 7/13/13, 4/5/17, 1/18/19

CLIENT INFORMATION

AKAIMS MDS ~ Staff to complete if client is unable.

Admission ~ Intake (continued)

Source of Referral: Check One

<input type="checkbox"/> Alaska Native Hospital (PHS or IHA) <input type="checkbox"/> Alcohol Detox or Residential Program <input type="checkbox"/> Alcohol Program <input type="checkbox"/> Anchorage Correctional Complex <input type="checkbox"/> Anvil Mountain Correctional Center <input type="checkbox"/> API <input type="checkbox"/> ASAP <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Attorney <input type="checkbox"/> Community Health Center <input type="checkbox"/> Correctional Agency (Probation, Parole) <input type="checkbox"/> Court – CINA Proceedings <input type="checkbox"/> Court – Civil Proceedings <input type="checkbox"/> Court – Criminal Proceedings <input type="checkbox"/> Crisis Recovery Center <input type="checkbox"/> Dentist <input type="checkbox"/> Department of Corrections/Jail <input type="checkbox"/> Developmental Disabled Program <input type="checkbox"/> Division of Vocational Rehabilitation <input type="checkbox"/> Drug Detox or Residential Program <input type="checkbox"/> Drug Program <input type="checkbox"/> DVSA – Victim Services <input type="checkbox"/> Emergency Department <input type="checkbox"/> Employer (EAP) <input type="checkbox"/> Family or Friend <input type="checkbox"/> Federal Probation <input type="checkbox"/> Goose Creek Correctional Center <input type="checkbox"/> Halfway House <input type="checkbox"/> Highland Mountain Correctional Center <input type="checkbox"/> Individual or Self-Referral <input type="checkbox"/> Internal Referral <input type="checkbox"/> Juvenile Justice <input type="checkbox"/> JSAP <input type="checkbox"/> Ketchikan Correctional Center <input type="checkbox"/> Not Applicable	<input type="checkbox"/> No Response <input type="checkbox"/> Nursing Home/Immediate Care Facility <input type="checkbox"/> Office of Children’s Services <input type="checkbox"/> Other Mental Health (not including psychiatrist), Including School, Church <input type="checkbox"/> Other CMHC Outpatient Caseload <input type="checkbox"/> Other Residential/Institutional <input type="checkbox"/> Other Social/Community Agencies <input type="checkbox"/> Outreach Team <input type="checkbox"/> Out of State Court <input type="checkbox"/> Out of State Medical <input type="checkbox"/> Out of State Psych or Res. Treatment <input type="checkbox"/> Partial Care or Day Care Program <input type="checkbox"/> Peer Support <input type="checkbox"/> Physician <input type="checkbox"/> Point Mackenzie Correctional Farm <input type="checkbox"/> Private Psychiatric Hospital <input type="checkbox"/> Psychiatrist or Psychiatric Outpatient Clinic <input type="checkbox"/> Public Health (HS, PHS, Div. of Public Health) <input type="checkbox"/> Public Safety <input type="checkbox"/> School <input type="checkbox"/> Social Services <input type="checkbox"/> Spring Creek Correctional Center <input type="checkbox"/> Supervised Apartment <input type="checkbox"/> Therapeutic Court <input type="checkbox"/> Transitional Housing <input type="checkbox"/> Tribal Court <input type="checkbox"/> Tribal Health Authority <input type="checkbox"/> Tribal Health Facility <input type="checkbox"/> V.A. Hospital <input type="checkbox"/> Village Health Aide <input type="checkbox"/> Wildwood Correctional Center <input type="checkbox"/> Youth Court <input type="checkbox"/> Yukon Kuskokwim Correctional Center <input type="checkbox"/> Other _____
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Admission ~ Intake (STAFF COMPLETES THIS SECTION)

1. **Admission Date:** ___/___/___ (same as date of Assessment) Treating **Here for:** Mental Health (always)
2. **Admission Type:** ___ First Admission ___ Readmission **Mental Health Problem:** YES (always)
3. **Admission Staff:** _____ **Opioid Replacement Therapy Planned:** NO (always)
4. **Client Type:** ___ Adult Severely Mentally Ill w/Substance Use Disorder
 ___ Adult Severely Mentally Ill w/NO Substance Use Disorder
 ___ Adult Emotionally Disturbed w/Substance Use Disorder
 ___ Adult Emotionally Disturbed w/NO Substance Use Disorder
 ___ Youth Emotionally Disturbed w/Substance Use Disorder
 ___ Youth Emotionally Disturbed w/NO Substance Use Disorder
 ___ Youth Severely Emotionally Disturbed w/Substance Use Disorder
 ___ Youth Severely Emotionally Disturbed w/NO Substance Use Disorder
 ___ Youth or Adult w/Substance Use Disorder ONLY

For Staff Use Only:
 Clinician/Staff Initials: _____
 Data Entry Initials: _____

Client Last Name, First Initial: _____
 Client ACMHS Number: _____
 Last updated 7/13/13, 4/5/17, 1/18/19

**Alaska Behavioral Health
CLIENT FINANCIAL POLICIES**

CLIENT NAME: _____

CLIENT #: _____

Assumption of Responsibility

The undersigned, responsible party agrees whether he/she signs as guarantor or as Client that in consideration of services to be rendered, to the Client named above, that the responsible party will guarantee the payment of all charges for such services and incidentals incurred by said Client. Delinquent fees may be turned over to a collection service and reported to the Credit Bureau of Alaska.

The undersigned, responsible party agrees to pay the Organization (Alaska Behavioral Health) the stated percentage of the actual charge per visit that is set in the current fee set. The agreed upon fee is payable at the time of service.

The undersigned, responsible party agrees to advise the Organization of any changes in financial status.

Authorization to Release Information

The undersigned, responsible party hereby authorizes the Organization to release demographical and medical information officially acquired in the course of examination and treatment for the purpose of filing for insurance benefits and other financial coverage.

Insurance Information

It is the practice of this Organization to accept most major medical insurance companies, Medicaid, and Medicare. It is the Organization's goal to provide fast and efficient billing as a *courtesy* to the client. Our Organization needs the clients' and/or responsible parties help to accomplish this goal. The clients' providing complete and accurate insurance information is necessary. All clients must complete the Alaska Behavioral Health Client Registration Form and give necessary information before seeing the Organization staff. It is the clients' responsibility to notify the Organization immediately if insurance or financial information changes.

Client Signature	Date
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Responsible Party Signature	Date
Please Print Name	Relationship to Client

ALASKA
BEHAVIORAL HEALTH



Informed Consent for Services by Student Interns

I, _____ (print name) client, parent or guardian, or authorized representative of _____ (print client name), understand that this Organization (Alaska Behavioral Health) trains undergraduate and advanced graduate students from the mental health profession who are not yet licensed in Alaska.

I understand that all students are supervised by a minimum of a Masters prepared Clinical Supervisor. Supervision includes face-to-face supervision sessions, reviewing and co-signing treatment plans, progress notes, and signing off on all other documents that go into your clinical record.

I understand that I have the right to know the name of the Student Intern, their supervisor and how to contact her or him; the staff member you meet with will provide this information upon request.

Decline Consent for Services by Student Interns _____
Signature Date

Your signature below indicates: 1) you have read the information in this document and consent to services provided by the Organization's Student Interns; 2) your Protected Health Information (PHI) is strictly confidential and is protected by Federal and State regulations (42 CFR Part 2; 45 CFR 160, 162, and 164; and 7 AAC 71.215).

Client Signature/Parent or
Guardian or Authorized Representative

Date

Name of Student (Print)

Date

Name of Supervisor (Print)

Date



Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
 - We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
 - We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

- We can share health information about you for certain situations such as:
 - Preventing disease
 - Helping with product recalls
 - Reporting adverse reactions to medications
 - Reporting suspected abuse, neglect, or domestic violence
 - Preventing or reducing a serious threat to anyone’s health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers’ compensation, law enforcement, and other government requests

- We can use or share health information about you:
 - For workers’ compensation claims
 - For law enforcement purposes or with a law enforcement official
 - With health oversight agencies for activities authorized by law
 - For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations.

ALASKA BEHAVIORAL HEALTH

Appointment Policy and Agreement

Scheduling an appointment serves as a reservation of time when we work with you in reaching your treatment goals. We are a team, so your regular attendance and active participation are important. Unfortunately, late arrivals for appointments prevent us from providing the highest quality care possible. Also, we are unable to refill prescriptions if we do not see you on a regular basis because of “no shows” and if you do not complete necessary laboratory work.

Please see below for the appointment guidelines which will assist you in receiving the highest quality of service and allow us to provide such service:

1. I agree to call and cancel appointments at least 24 hours in advance, or the day before any scheduled appointment that I cannot keep. Any appointment canceled on the day of that appointment, or that I am not present for at the start time of the appointment, will be considered a “no show.” *Emergencies will be taken into consideration.*
2. I agree to arrive on time for my appointments. I understand that late arrival may prevent me from being seen by a provider due to time constraints in which case I would need to reschedule my appointment. This may count as a “no show.”
3. I understand that subsequent no shows for medical provider appointments may result in no further scheduled appointments. If that happens, I will have the option to walk in and wait for a provider to see me and I understand there is no guarantee that an opening will be available with my preferred provider and/or that I will not have a long wait.
4. I understand that no further prescription refills will be available until I am seen in person by a provider.

Our mission is to promote wellness through behavioral health care services. Your health and safety are essential, and we are committed to be your provider of choice.

ALASKA BEHAVIORAL HEALTH



Consumer Grievance Process

It is the policy of our Organization (Alaska Behavioral Health) to treat all of our clients with dignity, respect, individuality, and with consideration for privacy. The Organization will provide all of its clients a process for reporting grievances in a respectful, timely, and fair manner without fear of retaliation.

1. Clients are asked and encouraged to review the form entitled *Client Rights and Responsibilities*. This form will be signed by the client at intake.
2. Clients or family members may ask someone to help them and be present during any/all grievance meetings. If asked, the Organization will provide help to clients who wish to file grievances.
3. The Organization will provide helpful resources to clients interested in filing grievances including the Disability Law Center, the Alaska Mental Health Consumer Web, NAMI Anchorage, NAMI Fairbanks, and NAMI Alaska, or any other known resource.
4. Clients are encouraged to talk about any concerns or grievances they have about their care and treatment at this Organization with their primary provider and/or that person's supervisor to work to fix the issue. If the problem cannot be fixed as described above, the client should fill out the Consumer Complaint form and submit it in a sealed envelope to the Deputy Privacy Officer.
5. The Deputy Privacy Officer will send a letter to the client within five (5) working days of receiving the complaint if not resolved at the departmental level. The letter will inform the client that the complaint has escalated to a grievance, has been received and the review process has been started. A written response to the grievance will be provided within thirty (30) working days after the review begins. If unable to resolve the grievance in thirty (30) working days, the Deputy Privacy Officer will explain the delay to the client in writing or by phone call.
6. For clients receiving publicly funded services, grievances unresolved to the client's satisfaction within thirty (30) calendar days shall be reported to the Division of Behavioral Health (1-800-770-3930 or 907-269-3600). Individuals may file a complaint with the Organization and the Secretary of the U.S. Department of Health and Human Services if they believe their privacy rights have been violated.
7. We have a "no tolerance" policy for abuse, neglect or intimidation being used to stop the filing of a grievance. We also do not tolerate retaliation for filing a grievance. Any report of abuse, neglect, or threats will be looked into and immediately reported to the Chief Executive Officer and the Organization's Board of Directors through the Corporate Operations committee. For clients receiving publicly funded services, the same will be reported to the Division of Behavioral Health.
8. The Client Grievance procedure will:
 - a. be available to all clients, legal guardians and to those denied services;
 - b. be summarized in a plain language form and given to the client or legal guardian and an acknowledgment signature form placed in the client's chart;
 - c. be prominently displayed in all Organization facilities.
9. Findings of grievances will be reported by the Deputy Privacy Officer to the Chief Executive Officer and the Organization's Board of Directors' Corporate Operations Committee. Reports will be a summary of all grievances received in the quarter.

CONSUMER RIGHTS AND RESPONSIBILITIES

Alaska Behavioral Health

YOUR RIGHTS

1. To get services without being treated unfairly due to race, religion, gender, age, place of origin, English proficiency, sexual orientation, marital status, or physical or mental abilities.
2. To be respected and treated with dignity and respect.
3. To be involved in your Treatment Plan, including the right to say no to certain services or to ask for specific services. If services cannot be provided, you have the right to be told why the service is not being provided or to be referred elsewhere for the service.
4. To be told by the person prescribing medications the name, purpose, possible side effects and drug interactions of any medication prescribed. You have a right to be told the risks and benefits of the medication, and the risk and benefit of not taking the medication.
5. To ask us to contact you by some method other than calling you at a home or work number. (e.g. calling a neighbor and leaving a message, email, etc.).
6. To have your health information kept confidential except as required or allowed by law and to review or get a copy of your records. Our Notice of Privacy Practices gives details about these rights.
7. To refuse experimental treatments, nonstandard treatment and participation in education or demonstration programs or research.
8. To make complaints or file a grievance without fear of retaliation.

YOUR RESPONSIBILITIES

1. To tell us why you are seeking services, about your problems, past illnesses, medications, and history.
2. To give complete, accurate and updated information to keep your clinical record current.
3. To ask questions about any information you do not understand.
4. To take an active role in your treatment (this includes families or guardians in the case of minor clients) and to work on treatment plan goals developed by you and your team.
5. To show respect for others, including respect for the confidentiality of others you see when you are here.
6. To talk about your concerns, complaints or grievances directly to staff and work to fix the problem.
7. To immediately report abuse, unethical or unprofessional staff behavior to Management.
8. To be financially responsible by giving all insurance information, current mailing address, paying bills, asking for financial counseling if needed, and following through with payment plans.
9. To come on time for appointments and to give at least 24 hours advance notice to cancel an appointment.

If you do not come on time for scheduled appointments or if you cannot be found by outreach staff for over 30 days or by case managers for 60-90 days, you may be discharged or be required to come during walk-in clinic time. If you are discharged for non-attendance you may ask to be re-admitted through the intake process.

ALASKA BEHAVIORAL HEALTH



Acknowledgement of Receipt of:
**HIPAA Notice of Privacy Practices; Consumer Rights & Responsibilities;
Consumer Grievance Process; and Appointment Policy and Agreement**

I acknowledge that I have received a copy of the **Alaska Behavioral Health HIPAA Notice of Privacy Practices** and have been given the chance to ask questions about it.

Signature of Patient, Parent, Legal
Guardian or Personal Representative

Printed Name

Date

I acknowledge that I have received a copy of the **Consumer Rights & Responsibilities** and have been given the chance to ask questions about it.

Signature of Patient, Parent, Legal
Guardian or Personal Representative

Printed Name

Date

I acknowledge that I have received a copy of the **Consumer Grievance process** and have been given the chance to ask questions about it.

I acknowledge I have received the **Appointment Policy and Agreement Form** and have been given the chance to ask questions about it.

Signature of Patient, Parent, Legal
Guardian or Personal Representative

Printed Name

Date

Staff Witness

Printed name

Date

Alaska Behavioral Health
CONSENT FOR ELECTRONIC COMMUNICATIONS

Email and texting

Our Organization (Alaska Behavioral Health) is able use Email and some texting to communicate with clients, upon mutual agreement between the provider and the client. This can be very helpful and convenient but is not guaranteed to be secure.

E-mail

We use an encrypted secure method to send and respond to Emails called CISCO. CISCO requires a onetime registration (at no cost to the Email recipient) to create a password. **If you do not wish to register with CISCO, we cannot communicate via Email with you.**

We will use the minimum necessary amount of Protected Health Information (PHI) to respond to any emails you may send to us. We will make every effort to keep PHI secure, in accordance with State and Federal law.

Email communication is a convenience and not appropriate for all circumstances. Please remember the following:

- **Emails are not to be used for emergencies or time-sensitive issues.**
- **Emails are not to be used as a therapy session.**
- **No one can guarantee the privacy of e-mail messages.**
 - For example, if your work e-mail is used, even though sent securely by us, your employer may have the right to access any e-mail received or sent from your work computer.
- **The Organization is not responsible for access of PHI due to your sharing or loss of your User ID and password, or an unattended email account.** Any PHI accessed in this manner is no longer protected by our privacy practices.

Texting

Texting is a convenient method of communicating brief information, but it is not secure. We have a system available for you to opt into that texts your next appointment as a courtesy reminder. This requires you to have a cell phone that is able to make and receive text messages. As another courtesy for our clients, select staff have a work cell phone available during **business hours only** for non-emergency texting.

Texting is:

- Not for emergencies
- Not to be used for therapy services
- **No one can guarantee the privacy of text messages.**
 - For example, if you use a work phone, or your work has the right to access your phone, your employer may have the right to view your text messages.
- May not be responded to immediately
- Can be used for messaging with your provider if you are running late to an appointment
- Can be used for resource reminders (e.g. breathing exercises; food bank hours; grounding techniques, etc.)

You are not required to use email or texting.

Fax Policy

The use of faxing can be very helpful and convenient but is not guaranteed to be secure. There is some risk that any PHI that may be contained in such fax may be disclosed to, or intercepted by, unauthorized third parties. We will use the minimum necessary amount of PHI and will make every effort to keep your information secure as required by law.

Alaska Behavioral Health
CONSENT FOR ELECTRONIC COMMUNICATIONS

Communication Consent

If you personally wish to communicate with us via Email, Fax, or texting please **initial the option below** and provide a valid email address and/or fax number.

_____ I do wish to communicate via email. Email address: _____
_____ I do wish to communicate via text. Cell number: _____
_____ I do wish to communicate via fax. Fax number: _____

OR **initial on the following page** if you do not want to communicate via Email, Texting or Fax:

_____ I do **NOT** authorize the following forms of electronic communication between me and my provider:
_____ Email _____ Texting _____ Fax

I understand the risks associated with electronic communications and initialed my communication preferences above. If I have authorized electronic communications, I do so with the following understanding:

- **Electronic communication methods can be misdirected to or intercepted and disclosed by unintended third parties and may not be a confidential form of communication. I understand and agree that electronic communication is being used for the convenience of myself and the ORGANIZATION does not warrant the confidentiality or security of this transmission.**

By signing below, you consent to the conditions described herein and agree to adhere to the policies set forth above, as well as any other guidelines that the Organization may impose for using electronic communications.

Signature	Date	Client Name	Relationship to Client
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Alaska Behavioral Health
CONSENT FOR ELECTRONIC COMMUNICATIONS

Telehealth Services

Telehealth services are provided for the convenience of our clients. Telehealth service is not required and is only used upon mutual agreement between provider and client. Telehealth services are subject to the following:

- Telehealth services are not the same as an in-person visit, as you will not be in the same room as your provider. If your provider determines that telehealth is not adequate for a particular issue, the provider may choose to terminate the session and request an in-person session.
- **Telehealth services will be scheduled in advance.**
- Telehealth services provided via computer should be accessed through a safe and secure connection. Be sure to use a computer that is in a confidential or private area and always fully close all online counseling sessions when they are complete.
- Telehealth services may also include online functionality, such as posting of notes or chat logs during the session. This information may be printed by your provider, and if so, it will be treated as confidential.
- If telehealth services cannot be conducted due to technical difficulties, you should immediately contact your provider to schedule a new session.
- **Telehealth services are not appropriate for emergency situations.**
- Some videoconferencing services, such as Skype, may retain certain personal information for its users. This could include user contacts and addresses, and other personal information you provide to the service. You should review the privacy policy for the internet service provider if you have any questions about the confidentiality of such information.

Telehealth Consent

Using telehealth services is entirely voluntary and will not impact the quality of care you receive from the Organization should you decide not to use these services.

Alaska Behavioral Health is not liable for any claims and/or damages arising from following:

- i. Interruption in the ability to conduct telehealth services due to technical difficulties, technical maintenance, or system failure.
- ii. Access by friends, family members or other third parties who may enter the room on the client side during telehealth sessions.
- iii. Breaches of privacy and security due to the fault of the third-party videoconferencing provider (such as Zoom, or Skype, etc.).

I understand the risks associated with telemedicine and initialed my preference above. If I have authorized telemedicine services, I do so with the following understanding:

- **Electronic communication methods can be misdirected to or intercepted and disclosed by unintended third parties and may not be a confidential form of communication. I understand and agree that electronic communication is being used for the convenience of myself and the ORGANIZATION does not warrant the confidentiality or security of this transmission.**

By signing below, you consent to the conditions described herein and agree to adhere to the policies set forth above, as well as any other guidelines that the Organization may impose for using electronic communications.

Signature	Date	Client Name	Relationship to Client
-----------	------	-------------	------------------------

Alaska Behavioral Health Child and Adolescent History Form

Full name of youth: _____ Date: _____
Date of Birth: _____ Current Age: _____ Gender: Male Female
Address: _____
Name of respondent(s) and relation to youth: _____

1) Identifying Information

- Who has legal custody of the youth? _____
- Who has physical custody of the youth? _____
- Ethnic background of youth: _____
- Is the Office of Children's Services (OCS) involved with the family? YES NO
If yes, name of current Social Worker? _____
- Has OCS been involved in the past? YES NO
If yes, when? _____
- Does the youth have a Guardian ad Litem (GAL)? YES NO
If yes, name of GAL? _____
- Does the youth have a Probation Officer (PO)? YES NO
If yes, name of PO? _____
- Who referred you to us? _____

What are the PRESENTING PROBLEM(s) and/or what makes you seek help at this time?

How long have these problems existed? _____

What changes would you like to see in your family and/or child?

Current Living Arrangements:

- | | |
|--|--|
| <input type="checkbox"/> Private residence | <input type="checkbox"/> Residential treatment (including assistant living home) |
| <input type="checkbox"/> Foster home | <input type="checkbox"/> Institutional setting (hospital, correctional facility, etc.) |
| <input type="checkbox"/> Moving between family and friends | <input type="checkbox"/> Crisis residence (short term stabilization) |
| <input type="checkbox"/> Homeless or shelter | <input type="checkbox"/> Other – Please describe: _____ |

2) Client History:

A) Early Childhood History

- Was pregnancy planned? YES NO
- Any problems during pregnancy or during birth? YES NO
Comments: _____

- Any health issues in first months/years of life? YES NO
Comments: _____

- At what age did the child:
Walk _____ Say their first word(s) _____ Become potty trained _____

B) Family History

- Father's name: _____ Mother's name: _____
- Stepfather's name: _____ Stepmother's name: _____
- Siblings/half siblings/step-siblings?

<u>First name of each sibling</u>	<u>Age?</u>	<u>How related?</u>	<u>Live in same home as the youth?</u>	
_____	_____	_____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
_____	_____	_____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
_____	_____	_____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
_____	_____	_____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
_____	_____	_____	<input type="checkbox"/> YES	<input type="checkbox"/> NO

- Who else is involved with raising this youth (grandparent, aunt, boyfriend, etc.)?

<u>Name</u>	<u>Relationship</u>
_____	_____
_____	_____
_____	_____

- How many adults live in the home? _____ How many total youth live in the home? _____
- What is the primary language spoken in the home? _____
- How many moves has the child experienced? _____
- What religion or faith tradition is practiced in the home, if any? _____

- Any family history of:
 - Incarcerations/jail/arrests YES NO
If yes, who and for how long? _____
 - Grief/Loss YES NO
 - Divorce YES NO
 - Domestic Violence YES NO

- Does the youth have any disruptive behaviors in the home? YES NO
IF YES, please describe these behaviors:

- What are the consequences when this youth misbehaves? _____

C) Trauma History

- Has the youth experienced any of the following:
 - Emotional abuse YES NO
 - Physical abuse YES NO
 - Sexual abuse YES NO
 - Severe accident(s) where their life was threatened YES NO
 - Neglect YES NO
 - Saw or heard someone else being hurt YES NO
 - Been exposed to community or school violence YES NO
 - Been exposed to caregiver substance abuse YES NO
 - If in OCS custody, lived in multiple foster homes YES NO

If you answered YES to any of these questions, please provide a brief description:

D) Substance Use History

- Are you concerned about abuse of drugs or alcohol for the youth? YES NO
If yes, please describe what substances are of concern: _____

- Any history of parental/caregiver substance abuse? YES NO
If yes, please describe: _____

E) Education and/or Work Experience

- Name of school or childcare where youth is enrolled: _____
- Grade or Level: _____ IEP in effect? YES NO History of suspensions? YES NO
- What are the youth's typical grades? _____

- Does the youth have a job? If so, where? _____
- Does the youth have any disruptive behaviors at school or work? YES NO
If YES, please describe these behaviors: _____

F) Community Functioning

- Is the youth involved in any extracurricular activities? (e.g. sports, Campfire, etc.) YES NO
If YES, what activities? _____
- Does the youth make friends easily? YES NO
- Does the youth have any disruptive behaviors in the community? YES NO
If YES, please describe these behaviors: _____

3) Mental Health/Psychiatric Treatment History:

- 1) Is the child taking any medications to treat behavioral/ emotional issues? YES NO
If YES, which medication(s): _____
- 2) Does the youth have a current mental health diagnosis? YES NO
If YES, what is the diagnosis? _____
- 3) Has the youth ever received community-based mental health treatment? YES NO
If YES, where, for how long, progress? _____

- 4) Has the youth ever been hospitalized or in long term residential mental health treatment? YES NO
If YES, where, for how long, progress? _____

- 5) Does the youth take part in any risky behaviors? YES NO
If YES, please describe? _____

- 6) Has the youth ever tried to hurt themselves? YES NO
If YES, please describe? _____

- 7) Has the youth ever attempted suicide? YES NO
If YES, please describe? _____

- 8) Is there any family history of suicide? YES NO
If YES, what is the person(s) relation to the youth? _____

4) Medical History:

- Does the youth have a primary care physician? YES NO
If yes, who and when last seen? _____
- Does the youth have any allergies? YES NO
If yes, to what? _____
- Does the youth have an established FASD diagnosis? YES NO
- Does the youth have any other medical problems? YES NO
If yes, please describe: _____

Respondent's Signature

Respondent's Printed Name

Date

Staff Witness Signature

Staff Witness Printed Name

Date

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 _____
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