Monday, September 27, 2021

ALASKA BEHAVIORAL HEALTH

Authorization to Release Health Information

Select Location — AKBH - Anchorage

Client Name — FULL CLIENT NAME

Date of Birth — CLIENT DOB

Address — CLIENT PHYSICAL OR MAILING ADDRESS
ANCHORAGE, AK, 99508

Phone Number — (907) CLIENT CONTACT #

Email — CLIENT-CONTACT-EMAIL@GMAIL.COM

I,Give Permission to:
YOU MAY USE RELEASE & OBTAIN TO COMMUNICATE TREATMENT NEEDS

Release Information to: | Obtain Information from:

In the Form of:
YOU MAY USE WRITTEN AND VERBAL TO COMMUNICATE TREATMENT NEEDS

Written | Verbal

Action to be taken
SELECT IF YOU WOULD LIKE US TO RELEASE, REQUEST, SEND ROI ONLY, OR FILE ROI ONLY FOR FUTURE USE

RELEASE AKBH RECORDS

Person/Agency Name (If requesting for yourself please enter your name) — AGENCY TO RELEASE/REQUEST/OR COMMUNICATE WITH
ENTER AS MUCH INFORMATION AS POSSIBLE WHEN ADDING PERSON OR AGENCY WHO WILL BE RECIEVING/RELEASING/COMMUNICATING WITH US

Person/Agency Address (if known) — ADDRESS OF COMPANY TO RELEASE/REQUEST OR COMMUNICATE WITH
ANCHORAGE, AK, 99508

Person/Agency Phone Number — (907) AGENCY/PERSON CONTACT #

Fax Number (if known) — (907) AGENCY/PERSON FAX #

Purpose of Information:
WHAT IS THE REASON WE ARE RELEASING/REQUESTING/COMMUNICATING WITH THIS PERSON OR AGENCY

Treatment Planning | Benefit/Support | Coordinate Treatment | Personal Use | Legal Use

SELECT REASON WE ARE RELEASING/REQUESTING/COMMUNICATING RECORDS

Information to be Released/Requested:
WHAT INFORMATION WOULD YOU LIKE REQUESTED/RELEASED/COMMUNICATED WITH THE PERSON OR AGENCY

Admission/Intake Summary | Psychiatric Evaluation

Discharge Summary | Medical Progress Notes
Treatment/Safety Plan | Medication Records
Clinical Progress Notes | Lab Results
Case Management Notes | Audio/Vidiography

SELECT ALL RECORDS YOU WANT TO RELEASE/REQUEST/COMMUNICATE

Substance Abuse Treatment (I am authorizing the release of substance use information from my record)

Yes

IF THE CLIENT HAS HAD SUBSTANCE ABUSE TREATMENT YOU CAN AUTHORIZE OR DECLINE TO RELEASE/REQUEST/COMMUNICATE THIS INFORMATION BY SELECTING YES OR NO

• 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 ACMHS 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 AKBH 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 AKBH in preparing a copy of records I may request for myself as allowed by State and Federal guidelines.

One time disclosure only:

Yes

IS THIS A ONE TIME DISCLOSURE OR WILL IT BE NEEDED FOR ONGOING CARE TO RELEASE/REQUEST/COMMUNICATE FOR A PERIOD OF TIME UP TO 1 YEAR

By checking 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.

Signature (use your finger or computer mouse to draw signature)

Date Monday, September 27, 2021

Name NAME OF SIGNER,THIS MAY NOT ALWAYS BE THE CLIENT PLEASE INDICATE RELATIONSHIP TO CLIENT

SIGNER NAME

Relationship to Client

Parent