Alaska Behavioral Health

Authorization to Release Health Information

☐ AKBH – Anchorage/Wasilla ☐ AKBH – Fairbanks
☐ Cohen Clinic – Anchorage ☐ Cohen Clinic – Fairbanks

Main AKBH Records location 4020 Folker Street Anchorage, AK 99508 | Ph. 907.563.1000 Fax 907.375.3115

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
☐ ____Treatment Planning ☐ ____Continued Treatment ☐ ____Coordinate Treatment ☐ ____Benefits/Supports ☐ ____Other (Specify) ________ ______________________ ☐ ____Personal Use ☐ ____Legal Use	☐ Admissions/Intake Summary ☐ Discharge Summary ☐ Treatment/Safety Plan ☐ Psychiatric Evaluation ☐ Medical Progress Notes ☐ Clinical Progress Notes ☐ Case Management Notes ☐ Lab Results ☐ Substance abuse Tx ☐ Medication Records ☐ Videography ☐ Directing Clinician current TX Diagnosis ☐ 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:			
☐ Send For Records	☐ Send ROI Only	☐ Release Alaska Behavioral Health Records	☐ File ROI Only