AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

I, _____ **give consent re:** _____
Parent/Guardian Name *Client Name*

_____ _____
Client Date of Birth *Client SSN*

for Alaska Island Community Services to:

☒ **Disclose information to & obtain information from (*list below*)**
☐ ONLY obtain information from (*initial if limiting information direction*):
☐ ONLY disclose information to (*initial if limiting information direction*):

Name: _____
Address: _____
City, State, & Zip: _____
Phone: _____ **Fax:** _____

The type of information to be released/obtained:

☐ Intake Assessments/Evaluations
☐ Treatment Plans/Treatment Updates
☒ Written & Telephone Case Communications
☐ Interdisciplinary Team Communications
☐ Treatment Presence/Compliance and Session
☐ Progress Notes
☐ Psychiatric Assessments
☒ Entire Chart
☐ Other (*specify below*)

_____

for the purpose of:

☒ Completing assessments and aiding in current treatment
☐ Providing effective multidisciplinary treatment of individual
☐ Other _____

I understand that my records are currently protected under the Federal privacy regulations within the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 & 164. I further understand that the information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may re-disclose the information and it may no longer be protected by the HIPAA privacy law.

The Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, noted above, however, will continue to protect the confidentiality of information that identifies me as a client in an alcohol or other drug program from re-disclosure.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this authorization expires automatically as follows:

Expires one year from date of signature

(Specification of the date, event, or condition upon which this consent expires)

Should I decide to revoke this authorization prior to its expiration, I understand that I must do so in writing by contacting the AICS Privacy Officer (874-2373).

I understand that the covered entity seeking this authorization may not condition treatment, payment, enrollment in the health plan, or eligibility for benefits on whether I sign the authorization.

I understand that I am entitled to receive a copy of this authorization after it is signed.

A Copy of this Release is as Valid as the Original.

Parent/Guardian Signature: _____ **Date:** _____

Participant Signature: _____ **Date:** _____