Alaska Crossings
SEARHC Care Network

Authorization to Disclose Behavioral Health Protected Health Information

Client's Name: _____ Date of Birth: _____

I (we) authorize Southeast Alaska Regional Health Consortium, Alaska Crossings, PO Box 1231, Wrangell, AK 99929

TO DISCLOSE INFORMATION TO AND OBTAIN INFORMATION FROM (list below):

Name of Organization: _____ Contact Person: _____
Address: _____ Phone: _____
City, State, Zip: _____ Fax: _____

NOTE: CLIENT MUST INITIAL ALL THAT APPLY in BOTH sections below

Information to be Disclosed:	**For the Purpose Of:**
_____ Behavioral health assessment (most recent)	_____ Completing assessments and aiding in current treatment
_____ Behavioral health treatment plan (most recent)	
_____ Substance use disorder assessment (most recent)	
_____ Psychological and/or Psychiatric assessment (most recent)	
_____ Discharge summary/Final Report (most recent)	_____ Continuing care arrangements
_____ Attendance/compliance (for the past year)	
_____ Medications/dosages (for the past year)	
_____ Referral note (for admission for treatment and/or Medicaid funded travel)	_____ Travel arrangements
_____ Academic records (including grades, transcript and most recent IEP, 504 and/or IHP)	
_____ Immunization record (complete record)	
_____ Written & telephone case communications (during admission process and treatment)	_____ Billing
_____ Treatment planning and updates (during admission process and treatment)	
_____ Physical assessment & medical history dates_____ to _____	_____ Other (specify):
_____ Progress notes dates_____ to _____	
_____ Other (specify):	

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.

This form may be revoked at any time by submitting a written request to the address below, provided the information has not already been disclosed. This authorization expires 1-year from date of signing unless an alternate expiration date or event is indicated (not to exceed one-year).
Alternate expiration date/event: _____
We will not condition or deny treatment on completion of this authorization.

Even if patient is a minor the ***signature of the minor is required*** by *Federal Law* for disclosures when being treated by a program that provides substance use disorder diagnosis, treatment, or referral for treatment

_____ _____ _____ _____
Signature of Legal Guardian Date Signature of Client Date