THE BEHAVIORAL HEALTH WELLNESS CLINIC
Alaska Native Tribal Health Consortium
3801 University Lake Drive, Suite 205 Anchorage, AK 99508
Phone: (907) 729-2492 or (833) 642-2492 / Fax: (907) 729-3950

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Client Name: _____ Date of Birth:_____
Address: _____ Phone#:_____

I, Client, or my personal representative (parent or legal guardian) hereby authorize the Behavioral Health Wellness Clinic (BHWC) to use and disclose health information and substance use disorder treatment information with my treating health care providers. The information may be used/disclosed for the treatment, payment and health care operations and other permissible purposes under applicable law and regulations. The health providers rendering treatment may also use these information as necessary for its own treatment, payment or health care operations activities such as care coordination.

DISCLOSURES TO RECIPIENTS

I, Client, or my personal representative (parent or legal guardian) hereby authorize Behavioral Health Wellness Clinic (BHWC) to release health information and substance use disorder treatment information to the following (person or entity):

Name (person or entity):_____ Phone#:_____
Address: _____ Fax#:_____

TYPE OF INFORMATION TO BE RELEASED / REQUESTED

I authorize disclosure / discussion of the following (check appropriate boxes):

- □ All my BHWC behavioral health record information and substance use disorder information
- □ Only BHWC behavioral health information for the following dates:
  Date Range _____ to _____
- □ Only BHWC substance use disorder information for the following dates:
  Date Range _____ to _____

- □ Psychiatric Diagnostic Evaluation
- □ Brief Counseling and Individual Counseling Progress Notes
- □ Group Counseling Progress Notes
- □ Case Management Notes
- □ Letter of Confirmation of Care
- □ Other (Specify:) _____
- □ Date Range _____ to _____

FORM OF INFORMATION

- □ I authorize BWHC to disclose copies of my records as described herein.
- □ I authorize verbal discussion of my information as described herein.

PURPOSE OF DISCLOSURE

- □ Personal use
- □ Referral for treatment
- □ Continuity of care
- □ Other (Specify:) _____

LENGTH OF AUTHORIZATION

Unless revoked, this authorization is limited to the following time period, which must be no longer than reasonably necessary to serve

the purpose of the disclosure:

Beginning on the date of authorization. Expiring: upon my expiration/demise or □ Other (specify): _____

APPLICABLE LAW

By signing this authorization form, I understand and agree that: My protected health information and substance use disorder treatment information is protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and federal regulations governing the confidentiality of substance use disorder patient records, 42 CFR Part 2. Recipients of my information pursuant to this authorization may not further disclose my substance use disorder information without my consent, unless permitted under HIPAA; 42 USC § 290dd-242; and 42 CFR Part 2. Recipients will be notified of this obligation in the Prohibition on Re-Disclosure which must accompany all disclosures of my substance use disorder information. 42 CFR § 2.32. I may revoke this authorization in writing at any time by notifying BHWC, except to the extent that BHWC has already used or disclosed information in reliance on my authorization. I will not be denied services if I consent to disclosure, unless disclosure is necessary for BHWC's proper treatment of me, obtaining payment for my services, or its health care operations.

I have been given time to read, understand, and ask questions about this form.

SIGNATURE

_____ _____

Signature of Patient (*Including if Patient is a Minor*) Date

_____ _____

Signature of Parent or Court-Appointed Legal Guardian Date (*Where Required or Authorized to Consent Under 42 CFR § 2.15*)

_____ _____

Printed name of Parent or Legal Guardian (if applicable) Description of Legal Guardian's Authority (if applicable)

**Note: To sign for a patient, a legal guardian must be legally appointed by a court due to the patient's incompetency. 42 CFR § 2.15(a). Power of attorneys and other types of guardians (like those appointed due to a patient's minority) are not authorized to sign on a patient's behalf.*

For BHWC's Use Only:

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Date Received: _____

___Patient declined copy or __Copy Provided to Patient

_____

Name/Title of Staff Member Processing Request: