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 INFORMATION

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

RECORDS DISCLOSED FROM

I request client's information be sent by:

- □ ANTHC Behavioral Health Wellness Clinic
- □ Other (Provider/Agency Name): _____

TYPE OF INFORMATION TO BE RELEASED / REQUESTED

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

- □ Complete BHWC behavioral health record
- □ Behavioral Health Assessments
- □ Individual Counseling Progress Notes
- □ Group Counseling Progress Notes
- □ Case Management Notes
- □ Only BHWC behavioral health information for the following dates: From: _____ to _____
- □ Other (Specify:) _____

DISCLOSURES TO RECIPIENTS

Name (Provider/Agency Name):_____ **Phone#:**_____
Address: _____ **Fax#:**_____

PURPOSE OF DISCLOSURE

☐ Personal use ☐ Legal ☐ Coordination of Care ☐ State/Federal ☐ Insurance/Benefits
☐ Other (Specify): _____

LENGTH OF AUTHORIZATION

Expiration: This authorization will expire one (1) year from the signature date. If alternative expiration date is desired, provide date here: _____

Revocation: An authorization may be revoked at any time by written notice to BHWC. Revocation is not effective until notice is received and is not effective regarding disclosures made before revocation and where authorization was obtained as a condition of insurance coverage.

PATIENT RIGHTS

I understand that: (1) I have a right to receive a copy of this signed authorization upon request; (2) I have a right to refuse sign this authorization - BHWC may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on a decision to sign this form; and (3) I have a right to inspect or copy my health information. I may arrange to inspect or copy information maintained by BHWC by contacting BHWC. I may be charged a reasonable fee for copying costs.

REQUESTOR

I authorize the disclosure of health information described above. Information released under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal privacy standards, including HIPAA and the Privacy Act of 1974. A photo copy/fax of this form is as valid as the original.

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

SIGNATURE

_____ _____
Signature of Client (*Including if Client 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)

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: