Maniilaq Counseling and Recovery Center Authorization for Release of Information

PO Box 256 Kotzebue, AK. 99752-0256
Tel: (907) 442-7640 Fax: (907) 442-7822

Client Name: _____ Date of Birth: _____ Last 4 of SSN: _____

I: _____ (Name of client or guardian) authorize that information may be exchanged between the following:

Maniilaq Counseling and Recovery Center
(Please initial what you authorize)

_____ Release Information
_____ Mutually Exchange Information
_____ Verbally Exchange Information

And _____ for care received from _____to _____
(Name of Person or Agency) (Date) (Date)

Information to be released: (Please initial what you authorize)

___ Treatment Plan and Status ___ BH Diagnosis ___ Psychopharmacology
___ Behavioral Health Assessment ___ Discharge Summary ___ Activity Report
___ Substance Use History ___ Other: _____

Purpose for the release of this information: (please initial what you authorize)

___ Healthcare Referral ___ Legal
___ Coordination of Care ___ Other: _____

I understand that authorizing the disclosure of this information is voluntary. Individuals enrolled in licensed substance treatment (Part 2) programs have their substance-specific records protected by 42 CFR Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Pts. 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I might be denied services if I refuse to consent to a disclosure for the purpose of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This consent expires automatically 12 months from dated signature or on the following date: _____.

_____ _____
Client Name (Please print legibly) Client Signature Date

_____ _____
Guardian Name (Please print legibly) Guardian Signature Date

_____ _____
Witness Name (Please print legibly) Witness Signature Date

NOTICE TO THE RECIPIENT OF THE INFORMATION

This information has been disclosed to you from records protected by federal confidentiality rules (HIPAA and 42 CFR Part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.