Maniilaq Counseling and Recovery Center
Authorization for Release of Information

PO Box 256 Kotzebue, AK 99752-0256
Tel: (907) 442-7640 | Fax: (907) 442-7749

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 ____ ________________________________
(Name of Person or Agency) (Contact Information)

for care received from ____________________ to ____________________
(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.

Revised 02/01/2023