Sitka Counseling

113 Metlakatla St
Sitka, AK 99835

T 907-747-3636
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Authorization for Release of Information or Records

Client Name: _____ **Client DOB:** _____

Information to be shared between:
Sitka Counseling & Prevention Services
113 Metlakatla St. Sitka, AK 99835
(P) 907-747-3636 (F) 907-747-5316

Information to shared between:
Agency Name: _____
Individual Name (if applicable): _____
Phone: _____Fax: _____

1) Select ONLY one of following, A or B:

A) I authorize my entire record to be released. _____
Signature Date

B) **I authorize only the following information to be released:** (PLEASE INITIAL)

_____ Psychiatric Evaluation
_____ Behavioral Health/Substance Use Assessment
_____ Diagnosis
_____ Recommendations
_____ Treatment Plan/Updates
_____ Verification of Attendance/Participation
_____ Progress Report of Treatment
_____ Substance Screening Results
_____ Discharge Summary
_____ Financial Information
_____ Emergency Contact
_____ Follow-up Contact Information
_____ Document needed to Support Assistance/Benefits
_____ Other: _____

2) Complete each of the following:

How the information should be released:
_____ Verbal
_____ Written
_____ Mutual exchange of verbal or written information between the facilitates listed above and applicable to the type of records identified
_____ Other: _____

Purpose of this disclosure:
_____ Facilitate Involvement in Treatment Process
_____ Continuity of Care
_____ Case Management
_____ Processing Financial information/billing
_____ Other: _____

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R, 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 by the regulations. I also understand that **I may revoke this consent in writing at any time, except to the extent that action has been taken in reliance on it** and, in any event, this consent expires automatically as follows.

Through 1 year following discharge

(Specifications of the date, event, or condition upon which this consent expires (If not specified, valid for one year from date signed)

I understand that generally Sitka Counseling & Prevention Services may not condition my treatment on whether I sign a release of information form, but in certain limited circumstances, legal entities may require a release of information. By my signature below, I verify that I have read or had the information read to me and fully understand the meaning and contents. Furthermore, I authorize the information I have indicated to be shared with the designated recipient voluntarily. I understand I have the right to receive a copy of this authorization form and/or upon my written request, Sitka Counseling & Prevention Services must provide me with a record of any subsequent disclosures made for legal, administrative, or quality assurance purposes. I agree that a photocopy or facsimile copy of this document authorizes the same release of information as the original.

_____
Signature of Client, Parent, Guardian, Conservator, or Authorized Representative Date

_____
Witness Signature Date

Prohibition on Disclosure of Information: This release accompanies a disclosure of information that may concern a client in alcohol/drug abuse treatment from records protected by Federal confidentiality rules 42 C.F.R, Part 2. The Federal rules prohibit you from making any further re-disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R, Part 2. A general authorization for release of medical or other information is **NOT** sufficient for this purpose. The Federal regulations restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse client.

REVOCATION: I, _____, hereby revoke this authorization for release of information.

_____
Signature of Client, Parent, Guardian, or Authorized Representative Date

_____
Staff Witness Signature Date