Authorization to Release Protected Health Information

Send completed forms to CHOICES, Inc, Intake & Client Records

MAIL: 1231 Gambell Street, Anchorage, AK 99501 **OR** FAX: (907) 333 – 4383

A *Applicant Information*

Applicant Name		*Date of Birth*	*Phone Number*
Address	*City*	*State*	*ZIP*
Legal Representative Name	*Relation to the Applicant*		*Phone Number*

B *Authorization Statement*

By initialing _____ **I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form.**

INITIALS

C *Release Records From/Send Records To*

☐ **Release my records TO CHOICES, Inc.**

FROM			
	Name		
	Address		
	City	*State*	*ZIP*
	Phone	*FAX*	

☐ **Release my records FROM CHOICES, Inc.**

TO			
	Name		
	Address		
	City	*State*	*ZIP*
	Phone	*FAX*	

Federal law requires a **separate authorization to use or release information pertaining to **mental health, alcohol and substance use treatment, HIV/AIDS, and hereditary test results**. Write in the name of the agency if requesting this type of information.*

D *Description of the Protected Health Information to be Released*

1 Records to Release

Check (☒) each category of information you are authorizing to be disclosed:

☐ **Complete Record**	☐ Diagnostic Tests	☐ Medication Information
☐ **Summary/Abstract only**	☐ Laboratory/Pathology Results	☐ Immunization record
☐ Clinic Records	☐ Radiology Reports	☐ Itemized Billing Records
☐ Hospital Care	☐ EKG Report(s)	☐ Psychiatric/Psychological Evaluation
☐ Emergency Room Records	☐ Operative report	☐ **Other**

If checked ***other***, what type of information ▶ _____

☐ **I only want records for these dates of service** ▶ _____

☐ **Verbal Communication Only** – **Do Not Release Any Written Records**

2 In compliance with federal and state law, special permission is required to release the following records

Check **(☒)** ***AND Initial*** *next to the boxes if you approve the release of the following types of sensitive information:*

☐ _____ **Inpatient/Outpatient Mental Health/Developmental Disabilities Treatment Services**

☐ _____ **Alcohol or Other Substance Use Therapy and Treatment Services**

☐ _____ **HIV/AIDS and/or Other Transmittable Diseases Records**

☐ _____ **Hereditary Disorder and Other Genetic Testing**

This authorization is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act (HIPAA), 42 CFR Part 2, and the Privacy Act of 1974 (5 U.S.C §552a)

CONSENT TO DISCLOSE PRIVATE HEALTH INFORMATION (CONTINUED)

E *Method of Delivery*

Paper ▶	☐ Certified US Mail ☐ Fax ☐ Pick Up in Person	**Electronic ▶**	☐ Secure Email _____ ☐ Flash Drive/CD	**Verbal ▶**	☐ Voicemail ☐ Message

Important!	Information that is sent or communicated by phone/cell, facsimile (fax), mail, or electronic mail has the possibility of being intercepted and received by unauthorized individuals. My signature below indicates that I understand this and hereby authorize my information be sent to the intended recipient in the manner authorized on this form.

F *Purpose of this Authorization*

☐ Eligibility Review/Continuing Care/Discharge Planning ☐ Legal/Insurance ☐ Personal Use/Review	☐ Consultation/Second Opinion ☐ Billing/Payment ☐ Updating Record	☐ Other (*please describe*)

G *Expiration of this Authorization* *(Select only one option)*

This authorization will remain in effect for 12 months from the date signed below unless revoked or another date or event:

☐ From the date this authorization is signed until the ▶ *(Date: MM/DD/YYY)* _____.

☐ Until you (the client) cancel this authorization **in writing** to CHOICES, Inc. 1231 Gambell Street, Unit 300, Anchorage, AK, 99501.

☐ Until the following event occurs, specify event ▶ _____.

☐ Other, specify ▶ _____.

H *Conditions of Authorization:*

- I authorize CHOICES, Inc. and entities identified in this document to honor this authorization unless and until I revoke it in a written notice and the designated office at CHOICES, Inc. receives that notice. The revocation will not be effective for information that CHOICES, Inc. or the agency mentioned above, discloses between the time that this Authorization is signed and when the revocation is received. I also understand that without my signature, my request to release the information described above to a third party will not be honored.
- I understand that I have the right to receive a copy of this Authorization after I sign it. I may also request a copy by writing to the address listed on the front of this form.
- I understand that CHOICES, Inc. will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.
- I understand that health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient, and no longer protected by Federal Confidentiality regulations; however, the recipient may be prohibited from disclosing substance abuse information.
- I understand that alcohol and other substance use information that has been disclosed from records is protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit the recipient from making any further disclosure of information in this record that identifies me 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.
- I understand that authorized release of "Behavioral or Mental Health Treatment" is protected by AK State law. AS 47.30.845 prohibits a recipient from making any further disclosure of these records without the authorization of the patient, or as otherwise provided by law.
- I may refuse to sign this authorization

I *Signatures*

✘ _____ _____ _____

Client (Legal Representative) Signature | *Name (Print)* | *Date Signed*

_____ _____ _____

Witness Signature | *Name (Print)* | *Date Signed*

FOR CHOICES, INC. STAFF ONLY

Affix Client Label Here	*Date of Request:* *Processed by:* ☐ **Mail** ☐ **Fax** ☐ **Other** Revoked on:	☐ *Power of Attorney* ☐ *Court Order* ☐ *Copy of ID or Driver's License* ☐ *Applicable Fees Paid* ***Total Pages Released:*** ***Release ID:***