SEAVIEW COMMUNITY SERVICES

Box 1045, Seward, AK 99664
PHONE (907) 224-5257 FAX (907) 224-7081

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Name	Date of Birth	SSN

I hereby authorize the **Behavioral Health Department** program(s) of SEAVIEW COMMUNITY SERVICES to:

Check one or both: Release information to: _____ Obtain information from: _____

NAME/AGENCY: ____

ADDRESS: ____

For Revocation Stamp Only:

INITIAL EACH CHOSEN ITEM: Each item of information to be released must be initialed.

Regarding the following information: _____Written _____Verbal _____Electronic

PURPOSE OF DISCLOSURE, as specific as possible (initial each chosen item) (Why do you want this information?)	NATURE AND AMOUNT OF INFORMATION TO BE DISCLOSED, as limited as possible (initial each chosen item) (What information do you want released?)
Continued care/treatment	Admission/intake
Coordinate case/treatment	Discharge plans/summary
Early intervention services	Medical
Employment assistance	Psychological test/evaluation
Legal use	Progress notes
Personal use	Social or educational history
Other (specify)	Psychiatric evaluation
	Plan of care
	Assessment
	Other (specify)

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol 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 protects my other records and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke in writing this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows (no more than 12 months): I understand that generally SeaView Community Services may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

____
(Expiration date-cannot be valid for more than 12 months)

Client Signature	Client Printed Name	Date
Witness Signature (If being mailed, faxed or to witness client's mark)	Witness Printed Name	Date
Relative/Guardian/Authorized Person Signature	Relationship to Client	Date

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. This information has been disclosed to you or us from information protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you or us from making any further 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 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

OFFICIAL USE ONLY Date & Documents Sent: ____

In Case of Revocation, Review and complete the following checklist:

☐ E-mail Directing Clinician and Records Clerk to advise of revocation
☐ Submit original form to Records Clerk to file in client file & update AKAIMS.

1/95, 1/96, 1/97, 8/99, 12/99, 6/01, 12/01, 6/02, 4/03, 1/06, 4/08,6/10, 7/16