16600 Centerfield Dr., Suite 205, Eagle River, AK 99577 Phone: (907) 696-7466 Fax: (907) 726-0332 email: info@obhn.org

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name: ____ Today's Date: ________________________

Social Security Number: ________________________________ Patient's Phone Number:________________

Date of Birth: ____

I, ______________________________________(Parent or Guardian Name), authorize Orion Behavioral Health Network (OBHN) to

☐: Send Info ☐: Obtain Info ☐: Exchange Info

Person/Agency: ____

Phone Number:____

Fax Number: (For Office Use)____________________________________

This information is for the purpose of:

☐ Continued Treatment ☐ Legal

☐ Personal Use ☐ Other (please specify):____________________________

I understand that the information to be released includes information regarding the following:

☐ Drug/alcohol abuse, treatment, rehabilitation ☐ Psychiatric Treatment

☐ Therapy Services

DATE RANGE OF RECORDS

________________TO______________

☐ Discharge Summary

☐ Admission Summary

☐ Psychological Testing

☐ Verbal Information

☐ Lab/X-ray

☐ Treatment Plan

☐ Other (please specify) ________________

____

Any information will not be released by the above named person or organization to any other persons or organizations unless I so authorize.

Expiration & Right to Revoke Authorization:

Except to the extent that action has already been taken in reliance on this authorization, at any time I may revoke this authorization by submitting a notice in writing to the Orion Behavioral Health Network. Unless revoked earlier, this authorization will expire 1 year from the date on which it was signed, or upon the following date or event: ____.

Signature of Patient: ____ Date: ____________________________

Signature of Parent or Guardian: ____________________________________ Date: ____________________________

Relationship if other than Patient: ____________________________________ Date: ____________________________

Witness: ____ Date: ____________________________

If patient is a minor and 14 or older, Alaska state law requires the patient must sign to authorize the release of any drug and alcohol or reproductive information.

Prohibition on re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal Regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written authorization of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Federal regulations state that any person who violates any provisions of this law shall be fined not more than $500 in the case of a first offense and not more than $5,000 in the case of each subsequent offense.

This Release of Information facilitates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated thereunder." The Authorization for Release of Information must state that once the requested PHI is disclosed, the PHI's recipient may re-disclose, therefore the Privacy Regulations may no longer permit it.