16600 Centerfield Dr., Suite 205
Eagle River, AK 99577
Phone: (907) 202-9238 Fax: (907) 726-0332
Email: info@obhn.org

AUTHORIZATION FOR RELEASE OF INFORMATION

Patients Name:_____ Today's Date:_____
Patient's Phone Number: _____ Date of Birth:_____

Please read carefully and ensure all highlighted areas are filled in.

I_____ authorize Orion Behavioral Health Network (OBHN) to:
(Parent or Guardian Name)

Must select at least one box:

☐ Send Info ☐ Obtain Info ☐ Exchange Info

Person/Agency: _____ Phone Number:_____
Fax Number (if known): _____

This information is for the purpose of: (Must select at least one box)

☐ Continued Treatment ☐ Legal ☐ Personal Use ☐ Other:_____

I understand that the information to be released includes information regarding the: (Must select at least one box)

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

Date Range of Records _____TO_____(Select all that apply)

☐ Medical Management ☐ Therapy Treatment Summary ☐ Discharge Summary ☐ Admissions Summary
☐ Psychological Testing ☐ Verbal Information ☐ Treatment Plan ☐ Lab/X-ray

Other: _____

Information will not be released by the above-named person or organization to any other persons or organizations.

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:_____ or ☐ Termination of Care ☐ Turns 18 yrs old

Signature of Patient:_____ Date:_____

Signature of Parent or Guardian:_____ Date:_____

Relationship if other than Patient:_____

Signature of Witness:_____ Date:_____

If a patient is a minor and 14 or older, Alaska state law requires the patient to 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.