TANANA CHIEFS CONFERENCE
TRIBAL VOCATIONAL REHABILITATION

122 FIRST AVE, SUITE 600, FAIRBANKS, AK 99701 PH (907) 452-8251, ext. 3232, 3323, 3329 Fax (907) 459-3883

AUTHORIZATION FOR USE AND DISCLOSURE OF EDUCATION INFORMATION

Instructions: Fill out form in its entirety. If any section is incomplete, this form may be invalid and the request may not be processed.

Patient Name: ____ Date of Birth: ________________________

Patient Address: ____

Patient Telephone: ____

I authorize Tanana Chiefs Conference/___________________________________(vendors) to disclose/obtain employment/education information to/from the following (circle disclose and/or obtain):

Person/Organization:	Person/Organization:
Address:	Address:
Contact Number:	Contact Number:
Fax Number:	Fax Number:

Date of Service/s: From: ______________________________ To: __________________________________

Consumer ***must*** initial the specific confidential information:

____EDUCATION Reports ____Other: (please specify)____

The purpose or need for this disclosure is:

□ Eligibility Determination □ On-going Case Management □ IPE Development □ Other; please specify _____________

The information may be transmitted via (consumer ***must*** initial each approved communication method)
______ fax ______ verbal ______electronically (***required*** to complete duty to warn) _____hard copy

- I understand that if the person or entity that receives the health information is not a health care provider or health plan covered by federal privacy regulations, the health information above may be subject to redisclosure and no longer protected by these regulations.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.
- I understand that I may revoke this authorization in writing at any time by notifying the Privacy Official except to the extent that action has been taking in reliance on this authorization.
- **Unless revoked, this authorization will expire 6 months from the date signed or as specified:** __________________
- I may inspect or copy any information used/disclosed under this authorization. I have received a copy of this authorization.

I further acknowledge that the information to be released has been explained to me and certify that this consent is given on my own free will.

____ ___________________________

Signature of Patient or Legally Designated or Personal Representative Date

____

Please print name of Legally Designated or Personal Representative (if applicable)

If not signed by Patient, description of authority: ____

For TCC's Use:

Date Received: ____

□ Fees explained if needed: ________________________________

□ Verification of Identity and Authority_________________________

□ Identification: ____

□ Information sent by: ______________________________________

Date Revised: 04/09/2018 AMR

TANANA CHIEFS CONFERENCE
TRIBAL VOCATIONAL REHABILITATION

122 FIRST AVE, SUITE 600, FAIRBANKS, AK 99701 PH (907) 452-8251, ext. 3232, 3323, 3329 Fax (907) 459-3883

AUTHORIZATION FOR USE AND DISCLOSURE OF EDUCATION INFORMATION

Preferred Method of Communication: Duty to Warn

Please use this form to let us know of the method you prefer we use in communicating with you. You have the right to request to receive communications about your protected health information from us by alternative means or at alternative locations and we will accommodate reasonable request/s.

Name of Client: ___________________________ Today's Date: _________________
Date of Birth: ____________________________

You do not need to tell us why you are making this request.
You may change your mind at any time and we will provide you with another copy of this form to request modification of your preferred method of communication.

<u>If You Prefer Email, Telephone Messages or Fax</u>
You may request that we communicate with you by email, telephone message and/or fax. We must warn you there is some level of risk that protected health information transmitted by unencrypted email and/or unsecured fax could be intercepted or read by an unauthorized person. In light of this warning, if you still prefer that we communicate with you by unencrypted email and/or unsecured fax we will agree to your request. We are not responsible for unauthorized access of your protected health information while in transmission or for safeguarding information that has been delivered to you.
You may check one or more boxes below or if your preference is not listed please provide specific directions in the space provided following the check boxes.

I request you communicate with me by:

1. **Telephone**
   - **Call my Home Phone**- Number____
     (Please select a box)
     ☐ This is my preferred method of communication and is okay to leave a detailed message.
     ☐ This is my preferred method of communication, but do not leave a detailed message.
   - **Call my Cell Phone**- Number ____
     (Please select a box)
     ☐ This is my preferred method of communication and is okay to leave a message.
     ☐ This is my preferred method of communication, but do not leave a message.

Email:
Preferred Email Address: ____

Fax:
Preferred Fax Number: ____
I further acknowledge that this consent is given on my own free will.

____
Signature of Client | Printed Name | Date

____
Signature of Parent/ Legal Guardian *(if required)* | Printed Name | Date

For TCC's Use:
Date Received: ______________________________________
□ Fees explained if needed: _____________________________
□ Verification of Identity and Authority_____________________
□ Identification: ______________________________________
□ Information sent by: ___________________________________