Tanana Chiefs Conference Behavioral Health Division
122 First Avenue, Suite 400, Fairbanks, AK 99701 Telephone (907) 459-3800 Fax (907) 459-3810

BEHAVIORAL HEALTH AUTHORIZATION FOR RELEASE OF INFORMATION

Each section of the form must be completed; missing information will result in delays in processing and may be invalid.

Check Box for ROI type: □ Individual □ Third Party Payer □ Treating Provider Recipient □ Non-Treating Provider (Must list name(s) of person(s) to receive information) Specific name of the person to which the disclosure is to be made: _____

PATIENT INFORMATION:
Patient Name: _____ Birth Date: _____ Medical Record # (if known): _____
Address: _____ City/ State/ Zip: _____

I Hereby Authorize TCC Behavioral Health Division to Disclose Information TO:
Name of Facility/ Organization/ Individual: _____
Address: _____ City/ State/ ZIP: _____
Phone Number: _____ FAX: _____

I Hereby Authorize TCC Behavioral Health Division to Request Information FROM:
Name of Facility/ Organization/ Individual: _____
Address: _____ City/ State/ Zip: _____
Phone Number: _____ FAX: _____

□ Dates of treatment: FROM: ____/____/____ TO: ____/____/____

□ Purpose or need for information being requested:
Further Treatment: _____ Legal Proceedings:_____ Insurance Claim: _____ Other (specify): _____

□ Type of Information to be used or disclosed:
_____ Acknowledge presence in treatment/attendance _____Diagnosis _____ Discharge Summary, status _____ Lab Reports
_____ Treatment Plan _____ Assessment/ Evaluation _____ Program compliance _____ Billing statements Other: _____

□ I authorize the release of information relating to: (Please **initial** which will be disclosed)
_____ Substance Use Disorder Information _____ Psychiatric/Psychological Treatment _____ AIDS, HIV, ARC/Medical

□ This information may be transmitted via: (please **initial** each approved communication method)
_____ Fax _____ Verbal _____ Electronically (**Required** to complete duty to warn) _____Hard copy

Unless revoked, this authorization will expire on the following date, event or condition: _____
If I fail to specify an expiration date, event or condition, this authorization will expire 180 days from the date of signing.

I understand that my substance use disorder treatment records are protected under the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and cannot be disclosed without my written consent unless otherwise provided for by those laws. I understand that the only personal representatives authorized to consent on behalf of a substance use disorder patient are legal guardians appointed by a court due to the patient's incompetency. 42 C.F.R. § 2.15(a), and that other personal representatives or powers-of-attorney are not so authorized. I understand that a minor patient's consent to disclosure is *always* required, even if parental consent is also required, except that legal guardians who have been court-appointed on behalf of a minor due to incompetency (but not due to minor age) may sign on a minor patient's behalf. I understand that I may revoke this authorization in writing at any time by notifying TCC, except to the extent that TCC has already used or disclosed information in reliance on my authorization. I understand that TCC must provide me with a copy of this authorization. I understand that I might be denied services if I refuse to consent to a disclosure for purposes of TCC's treatment, payment, or health care operations, and that I will not be denied services if I refuse to consent to a disclosure for other purposes. I understand that 42 C.F.R. Part 2 prohibits the recipient of these recipient from redisclosing them to others, except with my consent, or in compliance with Part 2's rules, and accordingly, TCC will provide recipients with the following written statement: This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient 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 C.F.R. part 2. A general authorization for the release of medical or other information is *NOT* sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

By my signature below, I certify that I have been given sufficient time to read this authorization, ask questions, and understand it:

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent or Legal Guardian (Where Required or Authorized to Consent on Behalf of the Patient) Date

_____ _____
Printed name of Parent or Legal Guardian (if applicable) Relationship to Patient

_____ _____
Signature of Witness Date

Tanana Chiefs Conference

PATIENT E-MAIL AUTHORIZATION FORM

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____

I authorize TCC to communicate my protected health information through e-mail, voicemail, or text message at the following:

☐ E-mail address: _____

By completing this authorization form, I understand and agree that:

- TCC will send a test email confirmation to the email address you provided. Please confirm that the email is active and accurate by responding to the test email with your name and date of birth. If TCC does not receive a reply within 5 business days, your records will automatically be mailed to the address you provided above. TCC will include "CONFIDENTAL" in the subject line of any e-mail, use a subject description that is as discrete as possible, and include a confidentiality statement in the body of the e-mail.

- The risks with using these methods of communication include, but are not limited to:
  - Messages may be sent to the wrong recipient or left at the wrong number; or
  - PHI sent to my e-mail account or accessed through an electronic device could be hacked, or otherwise inappropriately accessed if left unattended or lost.

- TCC cannot control or ensure the security of my PHI after it is sent via e-mail.

- I hold TCC harmless from any liability for sending my PHI by voicemail, e-mail or text message to the address or phone number listed above, including where my PHI is intercepted or inappropriately accessed due to hacking or failure to secure my accounts and electronic devices.

- I may revoke this authorization in writing at any time.

By my signature below, I certify that I have been given sufficient time to read this authorization, ask questions, and understand it:

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent or Legal Guardian (Where Required or Authorized to Consent on Behalf of the Patient) Date

_____ _____

Printed name of Parent or Legal Guardian (if applicable) Relationship to Patient

_____ _____

Signature of Witness Date

For TCC's Use Only: Date Received: _____ Description of Identity Verification: _____ Charges ($): _____

Name/Title of Staff Member Processing Request: _____ Date of Response/Completion: _____.

(Revised September 2019)