Tanana Chiefs Conference

Health Information Management
1717 W. Cowles Street Fairbanks, AK 99701
907-451-6682 ext. 3630
Fax: 907-459-3814

RELEASE OF INFORMATION (ROI)

Each section must be completed. Missing information will result in delays and the form may be invalid.

ROI TYPE

- ☐ Medical
- ☐ Behavioral Health
- ☐ Dental

PURPOSE OF ROI

Check All that apply:

- ☐ Further Treatment
- ☐ Legal Proceedings
- ☐ School
- ☐ Insurance Claim
- ☐ Other: _____

PATIENT INFO

Patient Information:

Name: _____ Birth Date: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

RELEASE INFORMATION

I hereby authorize Tanana Chiefs Conference to: (select all that apply)

☐ Send/Disclose Records TO: ☐ Request Records FROM: ☐ Exchange Information with: (back and forth communication)

Name of Person/Facility/Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

EXPIRES

This form will expire (choose only one). *If no selection is made this authorization will expire one year from date of signature.*

☐ On this date: ___/___/___ (MM/DD/YY) ☐ Immediately after the information has been released

CONSENT

Confirm your consent. *If no selection is made this information will not be disclosed.*

☐ I do	☐ I do not	authorize the disclosure of information about HIV/AIDS
☐ I do	☐ I do not	authorize the disclosure of information about behavioral health record
☐ I do	☐ I do not	authorize the disclosure of information about substance use disorder

METHOD

- ☐ Verbal
- ☐ Fax
- ☐ Encrypted Email
- ☐ Hard Copy

REQUESTED RECORD DATES

Information to be used or disclosed:

- ☐ All Dates of Services

OR

- ☐ Individual Dates Specified Below

From ___/___/___ (MM/DD/YY) TO ___/___/___ (MM/DD/YY)

RECORDS REQUESTED

Check All that apply:

- ☐ All Clinical Records

OR

- ☐ Immunization Records
- ☐ Consultation Notes
- ☐ Radiology Reports
- ☐ Radiology Images
- ☐ Lab Reports
- ☐ OB/GYN
- ☐ Operative Reports
- ☐ History and Physical
- ☐ Health Summary
- ☐ Other: _____

SUD/BH DISCLOSURES

Substance Use Disorder or Behavioral Health (optional):

- ☐ Diagnosis
- ☐ Presence in Treatment
- ☐ Treatment Plan
- ☐ Assessment
- ☐ Provider Letter
- ☐ Medications
- ☐ Other: _____

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PATIENT INFO

Patient Information:

Name: _____ Birth Date: _____

PATIENT SIGNATURE

- I understand that I may revoke any authorization to release my records 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. Such a revocation will be effective when TCC receives notice.
- I understand that any 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.
- For substance use disorder records: 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. For all other records: I understand that TCC may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization, unless that care is either research related or provided solely for the purpose of creating Protected Health Information for disclosure to a third party.
- I understand that 42 C.F.R. Part 2 prohibits the recipient of substance use disorder records from re-disclosing them to others, except with my consent, or in compliance with Part 2's rules. I understand that any other records disclosed based on this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].
- I may inspect or copy any information used or disclosed under this authorization. I have been offered a copy of this authorization, or may request one at any time. I understand that this authorization is voluntary and that I may refuse to sign this authorization.

By signing, I certify that I have been given sufficient time to read this authorization, ask questions, and agree to disclosure.

_____ _____
Signature of Patient (If the records requested are substance use disorder records, the patient's signature is required for disclosure, even if the patient is a minor) Date

_____ _____
Signature of Parent or Legal Guardian (where required or authorized to consent on behalf of the patient) Date

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