Tanana Chiefs Conference
Behavioral Health

Completed by Patient

Completed by Staff

Patient Name: _____

Date of Birth: _____

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I authorize the Tanana Chiefs Conference (TCC) Behavioral Health Department to disc ed herein to other departments within TCC's Clinical Services Department. TCC's B es Behavioral Health Programs such as Graf Rheeneerhaanjii, Old Minto Family Recove ng First, Outpatient Mental Health Therapy, Psychiatry, Outpatient Addictions services, .

1 **Printed Name and DOB**

In addition to TCC's Behavioral Health Department, TCC's Clinical Services Department includes all clinical services provided at Chief Andrew Isaac Health Center, TCC Subregional Clinics, TCC Village based clinics, Community Health Aide Program, and Purchased and Referred Care.

☐ I would like to **2** **Optional** ervices Department to these specific providers or staff members: (optional). _____

Specifically, I authorize that the following types of information be disclosed:

☐ my name an on;

☐ records of ve th and behavioral health providers for coordination of care;

☐ my status as cohol/drug treatment services;

☐ initial and su eeds;

☐ summaries o essment results and history;

☐ summary of alcohol/drug treatment and mental health services plan(s), progress, compliance and completion;

☐ medications related to treatment of alcohol/drug abuse and/or mental health conditions;

☐ other: _____

3 **Patient Must Select All That They Authorize**

I authorize the follow

☐ Verbal comm

☐ Other: _____

4 **Verbal Must Be Selected At Minimum Other Options are: Email, Written, etc.**

I may revoke this consent at any time, except to the extent that action has been taken in reliance on it, and in any event, this consent expires:

☐ One year fro _____

5 **REQUIRED Check or Write a Date**

The purpose of the disclosure authorized in this consent form is to enable TCC's Clinical Services Department and its Behavioral Health Department to communicate about my care as necessary to ensure proper coordination of my health services.

Tanana Chiefs Conference

Behavioral Health

I understand that:

- My substance use disorder records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
- My mental health records are also specifically protected by state law, and may not be disclosed without my written consent unless otherwise provided in those regulations, such as for treatment purposes. AS 47.30.845.
- I may be denied services if I refuse to consent to disclosure of my records for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.
- Any revocation of my consent should be submitted in writing to TCC Health Information Management at 1717 West Cowles Street, Fairbanks, Alaska 99701.
- 42 C.F.R. Part 2 prohibits recipients of my substance use patient records from re-disclosure of such records to others, except as otherwise permitted by the Part 2 rules. The following prohibition will accompany any disclosure of my drug or alcohol patient records: "This record which has been disclosed to you is protected by Federal confidentiality rules (42 CFR part 2). These rules prohibit you from using or disclosing this record, or testimony that describes the information contained in this record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against the patient, unless authorized by the consent of the patient, except as provided at 42 CFR 2.12(c)(5) or as authorized by a court in accordance with 42 CFR 2.64 or 2.65. In addition, the Federal rules prohibit you from making any other use or disclosure of this record unless at least one of the following applies: (i) Further use or disclosure is expressly permitte ormation is being disclosed in this record or as otherwise permitte usiness ass t, pa ceived the ate as

1 **Staff must:**
1. **Fill in Name, Date, and Medical Record Number (1-4)**

6 **Sign**

I ledge that the information to be released has been explained to me, and certify that this consent

7 **Print** **of my own free will.**

8 **Date**

Signature of Patient/Client
**if patient is a minor and SUD information is authorized - minors signature is required*

Date

9 **DOB**

Printed Name of Patient/Client

Date of Birth (Required)

10 **Sign and completed if necessary (minor, guardian, etc)**

Signature of Parent/Guardian (if required)

2 **Once completed send to HIMs @ medicalrecords@tananachiefs.org or the tcchims bucket within Athena.**

Printed Name of Parent/Guardian

3 **If uploaded into Athena document should be classified as Admin-Medical Record Request - labeled as, 'Health Information Exchange Patient Consent', mark Data Entry Completed**

For TCC's Use:

- ☐ Name of staff/witness: _____
- ☐ Date Received: _____
- ☐ Verification of Identity and Authority
- ☐ Medical Record Number: _____
- ☐ Date of revocation(if applicable): _____