Southcentral Foundation

Dena A Coy Residential Treatment Program

Frequently Asked Questions

How do I get started?

All applicants are required to submit a completed application and a comprehensive substance abuse assessment completed within the past 6 months.

How long is the program?

Individual's progress through treatment at various rates so there is no predetermined length of stay. Typically women complete treatment in about 120 days.

Are there rules for phone calls and email?

A phone is available for use in the living area. Customers do not have access to email but postal mail is accepted. Cell phones are not allowed during treatment. If brought, your cell phone will be safely stored during your stay.

May I have visitors while in the program?

Visitors, 18 and older are permitted once orientation phase is completed and are required to attend a 1 ½ hour Visitor Orientation/Family Education group before visits can occur. Visits with biological and/or adopted children under the age of 18 can be coordinated with your Chemical Dependency Counselor after admission.

What are the nicotine & caffeine policies?

Dena A Coy is a SMOKE-FREE and CAFFIENE-FREE environment. Use of tobacco products is not permitted anywhere on the property or during program activities outside of the facility. NO EXCEPTIONS. For those who need it, we offer a nicotine cessation program upon approval from your primary care provider.

Can my child join me in treatment?

Dena A Coy has space for six children ages birth to 3 years old. Please contact the Intake Coordinator for more information and to discuss your parenting situation. Mothers are responsible for providing items necessary for their children's needs such as diapers, wipes, formula, car seat, clothing, and hygiene products.

Do I have my own room?

Women without children share a room with one roommate and share a bathroom with three other women. You will have your own bed, dresser, closet, and nightstand. Women with a child will be in a room with no roommate. In addition to the amenities above, rooms for a woman with a child include a crib or toddler bed, and changing table.

How will I get my medication while I am in treatment?

Dena A Coy Policy and Procedures mandate that all medication prescriptions entering the facility are valid and verified for your safety and wellness. Over the counter medications are available on-site with approved standing orders from your health care provider. While in treatment, prescribed medications will be delivered in a Mediset or picked up from a local Pharmacy. You and/or your family will be responsible for any co-pays or out-of-pocket expenses for purchasing prescribed medications.

What if I have legal issues pertaining to my participation in treatment?

Dena A Coy is a voluntary program not a locked facility. The program does not accept third party responsibility for customer-owners.

What is the cost of treatment?

Treatment expenses are the responsibility of the customer. Resources for payment include most major insurance companies and Medicaid/Medicare/Denali Kids Care. Payment for services is based on ability to pay; a discount fee application is available. Services will not be denied solely due to inability to pay.

What to Bring to Treatment at Dena A Coy

Please follow this list carefully. Due to space limitations, additional items are not allowed.
All personal belongings will be searched upon arrival for treatment.

Personal Belongings: Please limit yourself to 2 suitcases and one carry bag of belongings. Casual clothing: 5 – 7 day supply including shoes/socks, slippers, undergarments, shirts, pants, and pajamas. Seasonally appropriate outerwear; jacket, sweater, sweatshirts, boots, hat, gloves/mittens, etc.

Toiletry Items: Shampoo (2), conditioner (2), body soap (2), skin care items/lotion, toothpaste, toothbrush, deodorant, feminine hygiene products, and razors. One-quart size bag of make-up. (Toiletries must be in their original containers.)

Medications: All prescribed medications must be in their original prescription bottles.

Documents: A photo ID, CIB or Tribal ID card, Insurance card/Medicaid/Denali Kids Care, SNAP cards, WIC vouchers, legal /court documents.

Cell Phones: Use of cell phones is restricted. Cell phones may be brought and stored safely in the staff office until use is permitted.

Bedding: Pillows, sheets, a comforter, and towels are provided.

Miscellaneous Personal Items: Envelopes and stamps, water bottle, hobby or special interest items (craft materials, Sudoku, crossword puzzles, crocheting materials), photos of family and friends (may be in a frame, but frame must not have glass), Bible or Devotional and 12 Step reading materials.

Music: Portable Media Player without internet capabilities.

Women with Children: Women are responsible for all their child's needs while in treatment; diapers, formula, clothing, monitors, and car seat. (Cribs or toddler beds and changing tables are provided. Onsite childcare services are provided during scheduled program activities.

Laundry Facilities: Washers, dryers, detergent, iron and ironing board are provided at no cost.

Food/Snacks: Dena A Coy is a Food and Nutrition Services (FNS) certified treatment center and qualified to use SNAP benefits for all eligible residents while they reside in the facility. The DAC Authorized Representative will meet with you after admission to discuss your benefits.

What to Leave at Home

* Electronic devices with wireless internet access and/or video/camera capabilities.
* CDs or DVDs
* Food products, snacks, candy, gum, mints, beverages of any kind.
* Nonprescription or over-the-counter medications.
* Aerosol products including deodorant and hair spray.
* Valuables
* Clothing with explicit messages or photos, revealing clothing that show midriff, low-cut tops, spaghetti straps, short shorts (shorter than mid-thigh).

Southcentral Foundation
Dena A Coy
4130 San Ernesto Avenue • Anchorage • Alaska • 99508
(907) 729-5070 (voice) • (907) 729-6316 (confidential fax) • (800) 478-3343 (toll free voice)

REFERRAL FOR ADMISSION

Applicant Name: _____ **Date of birth:** _____ **Age:** _____

Alaska Native/Native American: ☐ **No** ☐ **Yes** **Native corp. or tribal enrollment:** _____

Residence Address (street/city/state/zip): _____

Mail address (if different from residence): _____

_____

Describe applicants motivation to commit to treatment:

☐ motivated (understands he needs help & willing to do what it takes to get it)

☐ ambivalent (acknowledges others see s/he has problem, but not fully prepared to deal with it or accepting treatment only with strong external pressure)

☐ denial (unwilling to accept that s/he has problem in spite of evidence to the contrary)

☐ resistant (denies problem, actively refusing or fighting efforts to provide help

Describe the main problem(s) for which the applicant is being referred. _____

_____

_____

What does the applicant describe as the main problem(s)? _____

_____

Has applicant ever been referred/received substance abuse/dependence treatment? ☐ **No** ☐ **Yes If YES, briefly describe, when, where, and the outcome** _____

_____

_____

_____

_____

Has there been a Substance Use Assessment in the last 6 months? ☐ **No** ☐ **Yes, where?** _____

_____

Is the Assesment attached to this referral? ☐ **No** ☐ **Yes**

Has applicant ever been referred/received mental health treatment? ☐ **No** ☐ **Yes If YES, briefly describe when, where, and the outcome** _____

_____

_____

_____

_____

_____

Is applicant receiving mental health treatment now? NO / YES **If YES, provider** _____

_____

Referral Completed by: _____ **Relationship to applicant:** _____

Referrer contact information (phone # / email address): _____

Referral Agent Signature: _____ **Date:** _____

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DENA A COY CUSTOMER PROFILE AND INTAKE

Name: _____ Date: _____

Maiden: _____ Date of Birth: _____

Marital Status: ☐married ☐living as married ☐widowed ☐separated
☐single (never married) ☐divorced; how long? ____

Race: ☐American Indian ☐Aleut ☐Athabascan ☐Haida ☐Inupiat/Inupiaq ☐Tlingit
☐Tsimshian ☐Yupik ☐Asian ☐Black/African American ☐Caucasian
☐Other Alaska Native ☐Native Hawaiian ☐Other ☐Pacific Islander

Ethnicity: ☐Chicano/other Hispanic ☐Cuban ☐Mexican American ☐Puerto Rican
☐Spanish/Hispanic Latino ☐Not Spanish/Hispanic/Latino/Mexican ☐Unknown

Military: ☐Active Duty; Combat ☐Active Duty; No Combat ☐Military Dependent
☐Never in Military ☐Retired from Military ☐Reserves or National Guard; Combat ☐
Reserves or National Guard; No Combat ☐Other _____

Legal Status: ☐OCS ☐Tribal Court ☐ASAP ☐Probation/Parole ☐Pending Charges
☐Outstanding warrants or cases pending ☐No involvement ☐don't know

Education: Highest grade completed: _____ ☐High School Diploma ☐GED ☐Baccalaureate Degree
☐College; # degree (# of years) _____ ☐Vocational Training Beyond High School
☐Degree/Certificates: _____

Employment: ☐Employed; part-time ☐Employed; full-time ☐Armed Forces ☐Seasonal (now) ☐Seasonal (done)
☐Unemployed; looking ☐Unemployed; not looking ☐Unemployed; disabled ☐Unemployed - Student
☐Homemaker ☐Not in labor force; Retired ☐Not in labor force; Inmate/Resident
☐Not seeking work ☐other

If employed, what type of work? _____

If unemployed, what is the date of your last job? _____

Readiness to Learn:
How do you like to learn? ☐watching ☐reading ☐listening ☐doing

What language is primarily spoken in your home? _____

Do you speak a second language? ☐no ☐yes; if yes, what language? _____

Do you need an Interpreter: ☐no ☐yes

Do you have any Special Needs? (Check all that apply)

☐Diagnosed memory and/or learning disabilities ☐Severe Hearing Loss or Deaf
Do you need auditory aides? _____ ☐hearing aids ☐other _____

☐Visual Impairment or Blind
Do you need visual aids? ☐magnifying glass ☐large print material ☐braille ☐other _____

☐Major Difficulty in Ambulating; physical limitations ☐Diagnosed chronic sleep problems
☐Organic brain disorder ☐Traumatic Brain Injury
☐other _____

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How did you hear about this program? Who referred you?

What problem(s) brought you here today? (Check all that apply)

- ☐ Alcohol problems
- ☐ Drug problems
- ☐ Alcohol and Drug problems
- ☐ Legal Problems
- ☐ Domestic Violence
- ☐ Marital/Relationship Problems
- ☐ Family problems (non-marital)
- ☐ Social/Interpersonal (other than family)
- ☐ Other:
- ☐ Psychological/emotional problems
- ☐ Suicide Attempt/Threat
- ☐ Depression
- ☐ Victim of Child Abuse
- ☐ Victim of Sexual Abuse
- ☐ Perpetrator of Sexual Abuse
- ☐ Perpetrator of Child Abuse

What are the goals you would like to achieve to improve your quality of living or recovery environment?

- ☐ Regaining custody of children/parenting issues
- ☐ Social network problem (i.e. drug using friends/acquaintances)
- ☐ Lack of sober, social support
- ☐ Lack of self-esteem, self-confidence, or positive identity
- ☐ Shame and guilt about hurting family or need to make amends
- ☐ Lack of structure and time management skills
- ☐ Lack of stress management skills
- ☐ Education issues
- ☐ Poor communication skills and/or poor conflict management skills
- ☐ Lack of motivation or procrastination
- ☐ Housing, or appropriate place to live
- ☐ Financial concerns or unpaid bills

Family/Social History:

Where were you born? _____ Where were you raised? _____

Where do you live currently? _____

Living arrangement:

- ☐ alone
- ☐ with parents
- ☐ homeless
- ☐ with children
- ☐ with other relatives
- ☐ incarcerated
- ☐ with spouse/significant other
- ☐ with non-related persons – roommate or friend
- ☐ shelter

Where and with whom will you live after completing residential treatment?_____

Are you Pregnant? ☐ no ☐ yes If yes: What is your due date?_____

Do you have children? ☐ yes ☐ no

Please list **all** of your children:

Name	Date of Birth	Where does this child live?

Are you the primary caretaker for any of your children? ☐ yes ☐ no

If yes, have you made arrangements for childcare? ☐ yes ☐ no

How has your alcohol and/or drug use affected your family?

Substance Use:

What is your drug of choice?

When is the last time you used alcohol or other drugs?

Have you ever injected drugs ☐ yes ☐ no

Do you use Tobacco Products ☐ no ☐ cigarettes ☐ smokeless tobacco (chew) ☐ other_____

Have you received substance abuse treatment services in the past 12 months? ☐ no ☐ yes If yes, please where:

What do you think will help you to stay clean and sober/prevent you from relapsing?

List your goal or goals for the future:

Describe your positive qualities or strengths:

Describe your personal challenges or things that make it difficult to reach your goals:

What would you like to gain from treatment that would support your recovery goals?

Spirituality:

During the past month, how would you rate your sense of connectedness, spirituality or relationship with a higher power?

☐ excellent ☐ good/improving ☐ fair/not changing
☐ not good ☐ very bad ☐ other:

How important is spirituality in your life?

☐ very important ☐ somewhat important ☐ not very important
☐ not at all important

How often do you spend time on religious or spiritual practices?

☐ every day or almost every day ☐ several times a month
☐ occasionally ☐ very rarely ☐ not at all

What is your religious affiliation? _____

Is there anything else that you would like us to know about your religious/cultural/spiritual practices?

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Community Support:

Are you attending community self-help programs, e.g., AA, NA, etc.? ☐yes ☐no
If yes, how many times have you attended in the past 30 days? _____
Do you have a sponsor or mentor in the community? ☐yes ☐ no

How supportive would you say the people closest to you are of your seeking substance abuse treatment at this time?

☐not very supportive ☐somewhat supportive ☐very supportive ☐not supportive or against

Who is your primary support in the community?

Mental health Summary:

Prior mental health treatment history: (Check all that apply)
☐no history ☐counseling ☐medication management ☐hospitalization

Are you currently involved in mental health services? ☐no ☐yes If yes, who/where?

During the past 12 months, did you take any prescription medication that was prescribed to treat a mental health or emotional condition? ☐no ☐yes
If yes, list type and dosage:

Physical Health Summary:

In general how would you describe your current health? ☐excellent ☐very good ☐good ☐fair ☐poor

Have you had any unplanned weight changes in the last 12 months? ☐no ☐yes If yes, please explain:

Do you have nutritional concerns? ☐no ☐yes If yes, please explain:

Do you have a primary medical provider? ☐no ☐yes If yes, who?

If you do not have health benefits, what is your financial plan for prescribed medications?

Do you have any allergies to foods or medications? ☐no ☐yes If yes, list:

Do you have any chronic health or pain issues? ☐no ☐yes If yes, please explain

Residential Contraband Agreement

Southcentral Foundation

The following items are prohibited from customer-owner use or possession while in Southcentral Foundation (SCF) residential programs:

> *Candles, incense, air fresheners, carpet fresh, matches, lighters, cigarettes or tobacco products of any kind, electronic cigarettes/vaporizers, firearms, ammunition, or weapons of any kind, loose razor blades, candy, gum, unmarked hygiene items or powder, Illegal drugs, herbal incense, drug paraphernalia, alcoholic beverages, and/or synthetic drugs including but not limited to synthetic cannabinoid, Spice/K2, and bath salts.*

Any illegal drugs or narcotic medications without an active prescription brought to the program may be reported to the Anchorage Police Department. Contraband found during your stay at SCF, will be confiscated and destroyed; random room searches will be conducted.

SCF prefers that medications, prescription or otherwise, not be brought to the program at admission. We understand that there are times when this is unavoidable. In those instances, prescription medications brought to the program must be included as an active prescription and reviewed upon admission to the program.

Active prescription medications will be taken to a pharmacy to be verified to ensure authenticity. Prescription medications that cannot be verified, any medications not noted on the medical clearance form, and any unidentifiable medication must be picked-up within 24-hours of admission. Meds that are unidentifiable include open prescription liquids, gels, and ointments.

Over-the-counter medications brought to the program cannot be administered (even if unopened or in sealed packaging). SCF will provide all over-the-counter medications approved by your provider after admission. Any over-the-counter medications brought to the program on the day of admission must be picked up within 24-hours. Items that cannot be picked-up will be destroyed according to Southcentral Foundation Procedure. It is your responsibility to disclose possession of medications or contraband items at the time of admission in order for these items to be sent home.

During admission, if a medication is discontinued or there is a dosage change, the inactivated medication will be destroyed.

I / we acknowledge that I have read and agree with the above information. If I have any questions regarding contraband items, I will discuss these questions with SCF residential employees.

_____ _____

Customer-Owner Signature Date

_____ _____

Parent/Legal Guardian Signature Date

Behavioral Services Division – All Programs Form Number: 034 Form Name: Agreement Category: Consent Page 1 of 1 Document (revision) Date – 04/08/2019	Name_____ Medical Record #_____ Date of Birth_____

HEALTH SCREENING AND CLEARANCE
TO PARTICIPATE IN TREATMENT SERVICES

The following documents are to be filled out by a Primary Care Provider.

1. Medical Information/medical clearance including TB Screening Results
2. Approval for self-administered Over-the-Counter Medications PRN

If you have not had a PPD (TB Screening) within the past 12 months, please schedule an appointment with your health Care provider and have the result included with or on your medical clearance form.

*Additional medical information or screenings may be required.

Name_____
DOB_____
MRN#_____

Southcentral Foundation's Behavioral Services Division
Dena A Coy Program

Southcentral Foundation

The following medical information form (or its equivalent) must be completed by your health care provider in order to participate in the Southcentral Foundation Program.

If there are any questions or concerns, please contact: _____

Name: _____ Date of Birth: _____

Does this patient have any detoxification needs prior to entering treatment?: ☐ **No** ☐ **Yes**

Are there any physical impairments/limitations: _____

Are there any communicable diseases: _____

Date of TB screening and results: _____

Is the patient pregnant?: ☐ **No** ☐ **Yes** EDC?: _____

PHYSICAL EXAMINATION

SYSTEM	NML	ABNML
HEENT		
Neck/Thyroid		
Heart		
Lungs		

SYSTEM	NML	ABNML
Abdomen		
Extremities		
Neurological		
Genital		

List known food, medication, or environmental allergies:

_____

☐ This patient has been medically evaluated and cleared to participate in counseling, education, and/or activity groups for 5-6 hours a day.

☐ This patient has been medically evaluated and cleared to live in group care.

☐ This patient is medically cleared to participate in moderate aerobic and strength training exercises.

Name_____
DOB_____
MRN#_____

List all current prescription Medications:

Medication	Dose	Frequency & Route	Indication

If the patient is prescribed addictive or narcotic medications, are there non-narcotic alternatives? ☐ **No** ☐ **Yes**

If yes, please list_____

☐ I have evaluated _____ and believe that this customer-owner is capable and competent to self-administer their own medications, as prescribed.

_____ _____ _____
Provider Signature & Credentials **Date** **Phone**

_____
Provider Name Printed

For Customer to Complete

I, _____, am able to self-administer the medications prescribed to me, including if needed, the physician approved over-the-counter medications above. I will be responsible to ask the staff to retrieve my medication from the secure area when it is time for me to take my medication. I will assist in the documentation process by documenting the medication I take at the time I take it on the "Self-Administration of Documentation form."

_____ _____
Customer Signature Date

Southcentral Foundation

BSD Health Care Provider Approval for Adult OTC PRN Medication(s) Order Form

Provider: *Mark* Yes or No for the following medication(s) to indicate your approval status
☐YES ☐No **Acetaminophen** (Tylenol) 1000 mg by mouth every 8 hours as needed for PAIN/HEADACHE/FEVER/MENSTRUAL CRAMPS ☐YES ☐No **Acetaminophen** (Tylenol) 650 mg by mouth every 6 hours as needed for PAIN/HEADACHE/FEVER/MENSTRUAL CRAMPS Maximum 2000mg/24 hours ☐ Maximum 3000 mg/24 hours ☐
☐YES ☐No **Ibuprofen** (Advil, Motrin) 400 mg by mouth every 6 hours as needed for PAIN/HEADACHE/MENSTRUAL CRAMPS/FEVER
☐YES ☐No **Naproxen** (Aleve) 200 mg (220 mg tab) by mouth every 8 hours as needed for PAIN/MUSCLEACHE/HEADACHE/MENSTRUAL CRAMPS/FEVER
☐YES ☐No **Calcium Carbonate** (Tums) 1000 mg by mouth every 4 hours as needed for HEARTBURN
☐YES ☐No **Bismuth Subsalicylate** (Pepto-Bismol) 30 ml or two 262 mg tablets by mouth every 4 hours as needed for HEARTBURN/INDIGESTION/DIARRHEA
☐YES ☐No **Docusate Sodium** (Colace) 100 mg by mouth two times daily as needed for CONSTIPATION.
☐YES ☐No **Anti-gas tablets** (Beano) 2 tablets by mouth before meals as needed for FLATULENCE/GAS
☐YES ☐No **Lactaid** 1 tablet by mouth when eating dairy products as needed for LACTOSE INTOLERANCE
☐YES ☐No **Multivitamin** take 1 tablet (or 2 gummy vits) by mouth daily as needed for NUTRITIONAL SUPPLEMENT
☐YES ☐No **Loratadine** (Claritin) 10 mg by mouth daily as needed for SEASONAL ALLERGIES
☐YES ☐No **Phenylephrine Hydrochloride** (Sudafed PE) 10 mg by mouth once daily as needed for SEASONAL ALLERGIES
☐YES ☐No **Oxymetazoline 0.05% solution nasal spray** (Afrin) 2 sprays each nostril 2 times a day as needed for NASAL CONGESTION
☐YES ☐No **Guaifenesin** (Robitussin) 10 ml by mouth every 4 hours as needed for COUGH
☐YES ☐No **Cough Suppressant** (Halls, cough drop) 1 lozenge by mouth every 1 hour as needed for COUGH/SORE THROAT
☐YES ☐No **Diphenhydramine hydrochloride** (Benadryl) 25 mg by mouth every 4 hours as needed for SEVERE ITCHING/NASAL CONGESTION. Consult health care provider if symptoms worsen or persist
☐YES ☐No **Diphenhydramine hydrochloride** (Benadryl) 50 mg by mouth at bedtime as needed for INSOMNIA. If used for 10 consecutive nights consult health care provider
☐YES ☐No **Nicotine lozenges** 2 mg lozenge by mouth every 2 hours as needed for 6 weeks for TOBACCO CRAVINGS ☐YES ☐No **Nicotine patches** as determined by a Tobacco Treatment Specialist or the Alaska Quit Line
☐YES ☐No **Benzocaine local anesthetics** (Orajel) apply gel directly to sore tooth or gum every 6 hours as needed for TOOTH/GUM PAIN
☐YES ☐No **Topical antibiotic ointment** (Neosporin) apply thin layer to affected skin area 2 times daily as needed for MINOR SKIN ABRASION/CUT/SCRAPES
☐YES ☐No **Hydrocortisone acetate 1% cream** apply thin layer to affected skin area 3 times daily as needed for ITCHING/SKIN IRRITATION
☐YES ☐No **Clotrimazole 1%** (Lotrimin) apply thin layer to affected skin area 2 times daily as needed for ATHLETE'S FOOT/JOCK ITCH/RINGWORM
ALLERGIES:

I, _____, am able to self-administer the medications prescribed to me, including if needed, the physician approved over-the-counter medications above. I will be responsible for asking the staff to retrieve my medication from the secure area when it is time for me to take my medication. I will assist in the documentation process by documenting the medication I take at the time I take it on the "Self-Administration of Medications Documentation form."

_____/_____ _____

Customer-owner Signature & Initials Date

I have evaluated _____ and believe that this customer-owner is capable and competent to self-administer their own medications, as prescribed. Please keep the above approved over-the-counter medications on file should it become indicated for the customer-owner to use for treatment of minor conditions while in the program. These orders are authorized for one year from the date of my signature, or until there has been a change in the customer-owner's condition that would affect their ability to self-administer their medications.

_____ _____

Provider Printed Name/Signature/Credentials Date

Phone Number_____

Updated 8/25/2023

ANMC Mediset Medicaid Qualifications

_____ has been referred to the ANMC Mediset
(patient name)

Program for the following reasons: (please check all that apply)

- x Living in a congregate living home; or Dena A Coy
- ☐ Recipient of home and community-based waiver services; or
- ☐ Eligible for Medicaid due to a disability; or
- ☐ Is an adult experiencing a serious mental illness; or
- ☐ Is a child experiencing a severe emotional disturbance

I authorize mediset services for the below patient:

_____

Patient name/DOB

_____

Provider

Southcentral Foundation (SCF) – Behavioral Services Division (BSD)
4175 Tudor Centre Drive, Suite 200, Anchorage, Alaska 99508
Health Information Management **Phone:** 907-729-6380 **Fax:** 907-729-5188

Southcentral Foundation

Authorization to Release Health Information

Name of Customer-Owner whose information is to be released:	Customer-Owner Date of Birth:	Medical Record #:
Name of Parent or Legal Guardian, if applicable: (required for minors)	Customer-Owner Contact Information (or legal representative, if applicable):	

I authorize SCF – BSD (Alaska Native Medical Center & Alaska Native Tribal Health Consortium)

Information From ☑ **RELEASE Information To** and/or ☑ **OBTAIN**

Organization / Person: Southcentral Foundation Detox

Address: 4330 Elmore Rd.

City / State / Zip Code: Anchorage, AK 99508

Main Phone Number / Fax Number: 907 729-6690/907 729-6699

E-Mail Address

How would you like to receive these records: ☑ Fax ☑ Mail ☑ Pick-Up ☑ Email

Description of Specific Information to be disclosed: ***(please check all that apply)*** **I authorize the inclusion of the following records in this request:**

☐ **Behavioral Health Records** ☑ **Substance Use Records** ☐ **SCF Detox Records** ☐ **Education Records**

☑ **Other:** Written/verbal/presence ☐ **Other:** _____

SCF-BSD will adhere to releasing/obtaining Minimum Necessary records. Indicate if other than Minimum Necessary is needed.

Service Date (From): _____ Service Date (To): _____ or Information Pertaining To: _____

Specific purpose of this release of information: ***(please check the best description)***

☑ Coordination of Care ☐ Personal Use ☐ Legal Use ☐ Emergency Contact ☐ Other: _____

I understand that authorizing the disclosure of the above information is voluntary and I understand that the information in my health record may include records relating to sexually transmitted diseases, drug and/or alcohol abuse treatment, psychiatric and mental health care, or other sensitive information. I understand that if I am seeking Behavioral Health Services, that the entity seeking this authorization will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization. I also understand that if I am seeking Drug and Alcohol Services subject to 42 C.F.R Part 2, that the entity seeking this authorization is not permitted to condition treatment, payment, enrollment or eligibility for benefits on the provision of a 42 C.F.R Part 2 compliant release for treatment purposes. I understand that I may request a copy of this authorization. I understand that a photocopy/fax of this authorization is as valid as the original. I understand that there may be a fee for copying associated with this request. **I understand that I have the right to revoke this authorization at any time except to the extent that information has already been released. Authorizations for the release of alcohol and drug abuse records protected by 42 C.F.R. Part 2 can be revoked verbally. Authorizations covering all other health information must be revoked in writing.** I hereby authorize the use or disclosure of the health information as described above.

Prohibition On Redisclosure: I understand that information only covered by HIPAA (45 C.F.R. Parts 160 & 164) is subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Act. I understand that health information covered by federal law 42 C.F.R. Part 2 (Alcohol & drug abuse records prohibits any further disclosure of information 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. **42 C.F.R. Part 2 prohibits unauthorized disclosure of these records.**

Expiration Date or Event: _____ (Unless otherwise specified, this authorization will **expire one year from signature date)**

_____ _____
Signature of Customer-Owner Signature Date

_____ _____
Signature of Parent / Legal Representative, if applicable Signature Date

REVOCATION SECTION: DO NOT complete this section when the authorization is initially signed. Only complete if the Customer-Owner wishes to revoke this authorization. ***I hereby request that this authorization to release information be revoked; effective on the date of my signature below.***

_____ _____
Signature of Customer-Owner / Parent / Legal Representative Signature Date
If Customer-Owner revokes verbally, Employee will enter their name and job title followed by the date the Employee received the revocation instructions

SCF Employee Use Only: Received from Facility: _____ By Employee: _____

Southcentral Foundation (SCF) – Behavioral Services Division (BSD)
4175 Tudor Centre Drive, Suite 200, Anchorage, Alaska 99508
Health Information Management **Phone:** 907-729-6380 **Fax:** 907-729-5188

Southcentral Foundation

Authorization to Release Health Information

Name of Customer-Owner whose information is to be released:	Customer-Owner Date of Birth:	Medical Record #:
Name of Parent or Legal Guardian, if applicable: (required for minors)	Customer-Owner Contact Information (or legal representative, if applicable):	

I authorize SCF – BSD to ☐ **RELEASE Information To** and/or ☐ **OBTAIN Information From**

Organization / Person: _____

Address: _____

City / State / Zip Code: _____

Main Phone Number / Fax Number: _____

How would you like to receive these records: ☐ By Fax ☐ By Mail ☐ Walk-In / Pick-Up

Description of Specific Information to be disclosed: ***(please check all that apply)***

	Assessments		Complete Health Record		Discharge Summaries
	Education Records		Medication Lists		Pharmacological Management Notes
	Group Notes		Therapy Notes		Transfer Summaries
	Treatment Plans/Treatment Plan Reviews		Written and / or Verbal Communication		Other:
	Other:		Behavioral Health Consultants Documentation from ANMC		

☐ **By checking this box, I authorize the inclusion of SCF Detox records in this request.**

Service Date (From): _____ Service Date (To): _____ or Information Pertaining To: _____

Specific purpose of this release of information: ***(please check the best description)***

☐ Coordination of Care ☐ Personal Use ☐ Legal Use ☐ Emergency Contact ☐ Other: _____

I understand that authorizing the disclosure of the above information is voluntary and I understand that the information in my health record may include records relating to sexually transmitted diseases, drug and/or alcohol abuse treatment, psychiatric and mental health care, or other sensitive information. I understand that if I am seeking Behavioral Health Services, that the entity seeking this authorization will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization. I also understand that if I am seeking Drug and Alcohol Services subject to 42 C.F.R Part 2, that the entity seeking this authorization is not permitted to condition treatment, payment, enrollment or eligibility for benefits on the provision of a 42 C.F.R Part 2 compliant release for treatment purposes. I understand that I may request a copy of this authorization. I understand that a photocopy/fax of this authorization is as valid as the original. I understand that there may be a fee for copying associated with this request. **I understand that I have the right to revoke this authorization at any time except to the extent that information has already been released. Authorizations for the release of alcohol and drug abuse records protected by 42 C.F.R. Part 2 can be revoked verbally. Authorizations covering all other health information must be revoked in writing.** I hereby authorize the use or disclosure of the health information as described above.

Prohibition On Redisclosure: I understand that information only covered by HIPAA (45 C.F.R. Parts 160 & 164) is subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Act. I understand that health information covered by federal law 42 C.F.R. Part 2 (Alcohol & drug abuse records prohibits any further disclosure of information 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. **42 C.F.R. Part 2 prohibits unauthorized disclosure of these records.**

Expiration Date or Event: _____ (Unless otherwise specified, this authorization will **expire one year from signature date)**

_____ _____
Signature of Customer-Owner Signature Date

_____ _____
Signature of Parent / Legal Representative, if applicable Signature Date

REVOCATION SECTION: DO NOT complete this section when the authorization is initially signed. Only complete if the Customer-Owner wishes to revoke this authorization. ***I hereby request that this authorization to release information be revoked; effective on the date of my signature below.***

_____ _____
Signature of Customer-Owner / Parent / Legal Representative Signature Date
If Customer-Owner revokes verbally, Employee will enter their name and job title followed by the date the Employee received the revocation instructions

SCF Employee Use Only: Received from Facility: _____ By Employee: _____ *Revised 7/18/19*