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: _____

Address: _____

City / State / Zip Code: _____

Main Phone Number / Fax Number: _____

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:** _____ ☐ **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: _____ ***Revised 4/11/2022***