Authorization to Release Health Information

SCF ROI Authorization Revised 3/17/2026

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 & Alaska Native Medical Center & Alaska Native Tribal Health Consortium to: ☐ **RELEASE Information To** and/or ☐ **OBTAIN Information From**

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 ☐ Detox ☐ Optometry ☐ Education

☐ Substance Use ☐ Dental ☐ Medical ☐ Other: _____

SCF 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 ☐ Legal Use ☐ At the Customer-Owner's Request ☐ Other: _____

☐ Personal Use ☐ Emergency Contact ☐ Treatment, Payment, and Healthcare Operations

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 may be 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 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 covered by HIPAA is subject to redisclosure 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 (Substance Use Disorder Patient Records) disclosed for treatment, payment, or health care operations may be disclosed in accordance with permissions in HIPAA, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against you. Federal rules restrict the use of information to investigate or prosecute with regard to any crime any patient with a substance use disorder, except as provided at 42 CFR Part 2, Subpart E. Records used or disclosed in accordance with 42 CFR Part 2 may be subject to redisclosure by the recipient and no longer protected by 42 CFR Part 2.

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 _____

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Southcentral Foundation