CHUGACHMIUT
AUTHORIZATION FOR DISCLOSURE OF SUBSTANCE USE DISORDER RECORDS

Patient Name: _____ Date of Birth:_____

Patient Address: _____

Phone #: _____

RECIPIENT

I authorize Chugachmiut to use/disclose my substance use disorder records to the following individual(s) or entity(-ies) (use specific names, no general descriptions):

_____

USE OF INFORMATION

The information will be used/disclosed for the following purpose (be specific):_____

_____

The receiving entity may also use this information as necessary for its own payment or health care operations activities, and to report data about my prescriptions to the Alaska Prescription Database Monitoring Program.

FORM OF INFORMATION

- ☐ I authorize Chugachmiut to disclose copies of my records as described in this form.
- ☐ I authorize Chugachmiut and its staff to verbally discuss my records as described in this form.

TYPE OF INFORMATION

DATE RANGE:_____ **TO** _____

I authorize disclosure of the following substance use disorder records (please initial):

_____	Acknowledge attendance in treatment	_____	Substance abuse assessment
_____	History pertinent to this referral	_____	Program compliance
_____	Diagnosis	_____	Prognosis
_____	Urinalysis results	_____	Psychological/Psychiatric assessment
_____	Treatment plan	_____	Psychological/Psychiatric reports
_____	Treatment records	_____	Medical Records
_____	Discharge summary, Status	_____	Other
_____	Treatment recommendations		

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LENGTH OF AUTHORIZATION

Unless revoked, this authorization expires on: _____
This time period must be no longer than reasonably necessary to serve the purpose of the disclosure. If left blank, this authorization will expire six months from the date of the client's signature.

APPLICABLE LAW

By signing this authorization form, I understand and agree that:

- My substance use disorder 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"). Recipients of my information pursuant to this authorization may not further disclose my substance use disorder records without my consent, unless specifically allowed under 42 C.F.R. Part 2 and HIPAA. Recipients will be specifically notified of this obligation. 42 C.F.R. § 2.32.

- I may revoke this authorization in writing at any time by notifying Chugachmiut, except to the extent that Chugachmiut has already used or disclosed information in reliance on my authorization.

- I will not be denied services if I refuse to consent to disclosure, unless disclosure is necessary for Chugachmiut's proper treatment of me, obtaining payment for my services, or its health care operations.

SIGNATURE

_____ _____
Signature of Patient *(Including if Patient is a Minor)* Date

_____ _____
Signature of Parent or Court-Appointed Legal Guardian Date
(Where Required or Authorized to Consent Under 42 C.F.R. § 2.15)

_____
Printed name of Parent or Legal Guardian (if applicable)

_____
Description of Legal Guardian's Authority (if applicable)

**Note: To sign for a patient, the guardian must be legally appointed by a court due to the patient's incompetency. 42 C.F.R. § 2.15(a). Power of attorneys and other types of guardians (like those appointed due to a patient's age) are not authorized to sign on a patient's behalf.*

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For Chugachmiut's Use Only:

Date Received:_____

Name/Title of Staff Member Processing Request: _____