AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Section 1

Name of Client: _____ DOB_____

Other Names Under Which Records Might Be Filed:

_____

Section 2

I authorize **Border Counseling Services LLC, 471 W. 36th Avenue, Suite 110, Anchorage, AK. 99503**

☐ To Send ☐ To Receive ☐To Exchange ☐ To Exchange Verbal

The following information: *(If substance abuse information must be specified)*
☐ Medical history and evaluation(s) ☐ Mental health evaluations ☐ Development and/or social history ☐ Education Records ☐ Progress notes, and treatment or closing summary
☐Other: _____

Name of Person/Organization: _____

Address: _____

Phone: _____ **Fax:** _____

The above information will be used for the following purposes:
☐ Planning appropriate treatment or program ☐ Continuing appropriate treatment or program
☐ Case review ☐ Updating file ☐ Other _____

I hereby authorize the use or disclosure of my health care and/or other information as described above. I understand that this authorization is voluntary. I understand that I may revoke this authorization at any time by notifying the individual(s) or organization releasing this information in writing, but if I do, it won't have any effect on actions taken on this authorization before my revocation was received. I understand that the individual(s) or organization releasing this information will not condition my treatment, payment, enrollment in a health plan (if applicable) or eligibility for benefits on whether I provide this authorization. I understand that if the person(s) or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential.
This authorization expires on the following date or event: _____ or 90 days from the date of signature if no other date or event is indicated.

_____/_____ /
(Signature of Witness) (Date/Time)

_____/_____ _____
(Signature of Patient/Guardian) (Date/Time) (Relationship to client

RECIPIENT INFORMATION: If the information released pertains to alcohol or drug abuse, the confidentiality of the information is protected by federal law (CFR 42 Part 2) prohibiting you from making any further disclosure of this information without the specific written authorization of the person to whom it pertains or as otherwise permitted by CFR 42 Part 2. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.