DENA'INA WELLNESS CENTER

AUTHORIZATION FOR USE AND DISCLOSURE OF CONFIDENTIAL HEALTH INFORMATION

508 Upland St. Kenai, AK 99611 – PH: 907-335-7525 – Fax: 888-490-2368 – medicalrecords@kenaitze.org

PATIENT INFO

Name: ______________________ **Birth Date**: ______________ **Phone Number**:______________________

Mailing Address:______________________________ **Previous or Other Names used:** ______________________

RELEASE INFO

I authorize the Dena'ina Wellness Center to:
(select all that apply)

☐ Disclose the health information described below **TO**:
☐ Request the disclosure of the health information below **FROM:**
☐ **Exchange** the health information below with:

Name of Person/Facility________ ______________________
Address: ______________________________
City: ____________________ **State:** ________ **Zip:** __________
Phone: ____________________ **Fax:** ______________
Email:____________________

Reason for Release: ☐ At the request of the patient ☐Legal ☐ Insurance/Benefits ☐School ☐ Other ______________

RECORD DETAILS

Type of Records to Release: ☐ Medical ☐ Behavioral Health ☐ Dental ☐ Optometry ☐ Billing ☐ Other ____________

Health Information to be Disclosed:
☐ Records for the following dates: From ___/___/___ To ___/___/___ **OR** ☐ Records of all dates of service

☐ Only information related to (check all that apply):
☐ Immunization Records ☐ Lab / Pathology Reports ☐ Radiology/X-ray Reports ☐ Physical Therapy
☐ **Other** (please specify i.e., only billing statements, injury, substance use assessments): ______________________

I authorize the following sensitive information to be disclosed (*optional*):

☐ Substance Use Disorder Records (specify in box to right →)
☐ Sexually Transmitted Infection (STI) Information ☐ HIV/AIDS Information
☐ Mental Health Treatment
☐ Other: ____________

SUD ONLY

Substance Use Disorder Records:
☐All records
☐Attendance in Treatment
☐Clinical Summary
☐Diagnosis ☐Treatment Plan
☐Assessment ☐Provider Letter
☐Other: ____________________

Method of Records Release: ☐Paper Copy ☐Fax ☐Encrypted Email ☐Disc ☐Verbally

EXPIRATION

I am aware that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it.*(See back page for revocation information)* If my authorization is not revoked, it will terminate **one year** from the date of my signature, unless a different expiration date or event is listed below:

☐ Date ___/___/______ ☐ Event: ______________________ ☐ This ROI expires immediately after records are released

PATIENT RIGHTS

- I understand that I have a right to receive a copy of this signed authorization upon request. I understand that aside from the above exception involving court-ordered participation, KIT will not condition my treatment, payment, enrollment in a health plan, or eligibility for health care benefits on a decision to not sign this form.
- I am aware that, but for substance use disorder records protected under 42 CFR Part 2 (see below), there is a potential that records disclosed under this authorization may be subject to re-disclosure and may no longer be protected under the Health Insurance Portability and Accountability Act (HIPAA) or the federal Privacy Act of 1974.
- **Substance Use Disorder Records:** I understand my substance use disorder records may be protected under 42 CFR Part 2, in addition to HIPAA, and that they cannot be disclosed without my written consent except as provided for in those regulations. However, if the designated recipient of this authorization is a covered entity or business associate under HIPAA, the information disclosed may be further disclosed by the recipient in accordance with HIPAA, except for uses and disclosures in connection with civil, criminal, legislative, or administrative proceedings against the patient.

SIGNATURE

Signature: ____________________________**Print Name**: ____________________________**Date**: __________________

☐**Self** ☐ **Parent/Guardian** ☐ **Legal Representative** ☐ **Other** ______________

STAFF ONLY

STAFF USE ONLY:

Documentation of Authority: ☐ID/Driver's License ☐School ID ☐Verbal/3 Identifiers ☐Personally Known

Staff Name: ____________________ Date Received: __________________

☐ **Original** authorization maintained in Health Record/EHR ☐ **Copy** of form to patient

Revocation of Consent for Release of Confidential Information

I, ______________________________, hereby revoke the authorization to release information I provided to Kenaitze Indian Tribe Health Services to use and disclose my protected health information as I outlined on the authorization form, which I signed on _______________(**Date of Authorization**) for release of my protected health information to __________________________(**Name of Person or Entity**). I understand that this revocation does not apply to any action of the Kenaitze Indian Tribe Health Services has taken in reliance on the authorization I signed earlier. This revocation does not revoke any and all other previous authorizations to release information that I have provided to the Kenaitze Indian Tribe Health Services.

SPECIAL PROVISIONS (optional)

In this section, the individual should outline any special provisions regarding the revocation of authorization.

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Signature: ___________________________ **Print Name**: ___________________________ **Date**: ________________

☐ **Self** ☐ **Parent/Guardian** ☐ **Legal Representative** ☐ **Other**

STAFF USE ONLY:

Received by: __________________________ **Date Received:** ____________________