

## CONSENT FOR DISCLOSURE OF INFORMATION

I, \_\_\_\_\_ DOB: \_\_\_\_\_, request/authorize Alaska Family Services to

\_\_\_\_\_ Disclose information to: \_\_\_\_\_ and/or \_\_\_\_\_ Obtain information from:  
(nature and amount of information to be disclosed; as limited as possible)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**Initial all that apply.**

_____ UA Results	_____ Attendance
_____ Assessment/Interpretive Summary	_____ Discharge Summary
_____ Treatment Plan/Case Reviews	_____ Leave message for client to contact agency
	_____ Other: _____
	_____

**For the purpose(s) of:**

_____ Further Treatment	_____ Personal
_____ Legal Request	_____ Other _____
_____ Coordination of Care	_____

Closure is to be: **verbally, in writing and/or by facsimile (fax).**

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: \_\_\_\_\_ 90 days after discharge, or \_\_\_\_\_ other terms: \_\_\_\_\_ (specification of the date, event or conditions upon which this consent expires) IF NOT PREVIOUSLY REVOKED, THIS CONSENT WILL TERMINATE ON \_\_\_/\_\_\_/\_\_\_.

I understand that generally Alaska Family Services may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

By my signature below I indicate that I have read this document or have had it read to me, that I fully understand its meaning, that I consent to its terms knowingly and voluntarily, that I have not been under any undue duress or influence nor under the influence of alcohol or drugs in making this agreement.

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_  
Client

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_  
Parent, guardian, or person authorized to sign for client

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_  
Witness

This notice accompanies a discloser of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information 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.