Cook Inlet Tribal Council, Inc.
3600 San Jeronimo Drive, Suite 138 Anchorage, AK 99508
Phone (907) 793-3132; Fax (907) 793-3173

Authorization to Use or Disclose Personal Information

Client's Name: ______________________________________ DOB: ___________ Last four digits of SSN: __________

I (______ Client _______ Parent _______ Legal Guardian) hereby authorize Cook Inlet Tribal Council (CITC) to:

☐ _______ **Release protected health and other information within and among CITC departments as indicated below.**

☐ _______ **Release and/or obtain (as indicated below) information from:**

ORGANIZATIONS AUTHORIZED TO RELEASE OR OBTAIN INFORMATION OUTSIDE CITC – Initial the box and indicate whether CITC is authorized to release information (R), obtain information (O) or both (R/O). The default is listed below – if you would like to vary from the default choices, please cross out or insert "R" or "O" accordingly:

☐ **R/O** Alaska Housing Finance Corporation

☐ **R/O** Alaska Native Medical Center/Alaska Native Tribal Health Consortium and the following health organizations:
__________________,__________________,______________,_____
__________________,___________________,______________

☐ **R/O** Anchorage School District * _________(other district)*

☐ **R/O** ANCSA Native Corporations (specify)_________,_________

☐ **R/O** Bureau of Indian Affairs

☐ **R/O** Billing Entities (listed at end of page 2)

☐ **R/O** Child Care Providers (specify): ____________________

☐ **R/O** Post-Secondary/vocational educational institutions and programs (specify): __________,__________,__________

☐ **O** Employers (specify): __________,__________,__________

☐ **O** Financial Institutions including Bank of America, Consumer Credit Counseling Services, JP Morgan, Wells Fargo (specify others):
____

☐ **R/O** Municipality of Anchorage and other local governments (specify others): ____

☐ **R/O** Social Security Administration

☐ **R/O** State of Alaska Bureau of Vital Statistics

☐ **R/O** State of Alaska Child Care Program Office

☐ **R/O** State of Alaska Child Support Services Division

☐ **R/O** State of Alaska Department of Labor

☐ **R/O** State of Alaska Department of Public Assistance

☐ **R/O** State of Alaska Division of Vocational Rehabilitation

☐ **R/O** State of Alaska Medicaid and its fiscal agent

☐ **R/O** State Military Affairs or Federal Veterans Administration

☐ **O** State of Alaska - Other (DHHS, Dept. of Law, Corrections, Education, Dept. of Revenue, Housing Authority), (circle applicable entities and specify any others):
____

☐ **R** State of Alaska - Other (DHHS, Dept. of Law, Corrections, Education, Dept. of Revenue, Housing Authority), (circle applicable entities and specify any others):
____

Other R/O (specify):
Name: _______________________________ ____
(Facility, Organization, or Individual Name)
Address: ____ Phone/Fax: ___________________________

PURPOSE OF INFORMATION:	WRITTEN AND VERBAL INFORMATION REQUESTED and/or RELEASED: (check all that apply and initial)
At the request of the client for the purpose of treatment or services. I understand that although this ROI provides CITC with the authority to release my information, CITC policies require that information only be released as necessary for the provision of services and to the minimum extent necessary. Other specifications, if any ___________________________ ___________________________ **Psychotherapy Notes CAN NOT be released with this Authorization – see Psychotherapy Authorization to obtain those records**	☐ _______ Application for Services ☐ _______ Admission Summary ☐ _______ Psychosocial History ☐ _______ Treatment Plan (clinical) ☐ _______ Discharge Summary ☐ _______ Psychological Evaluation ☐ _______ Psychiatric Evaluation ☐ _______ Education assessments* ☐ _______ FAS/FASD Assessments ☐ _______ Legal History ☐ _______ Other (specify)__________ ☐ _______ Health History/Physical Records ☐ _______ Lab Reports ☐ _______ Medication Records ☐ _______ Career Development Assessment ☐ _______ Substance Abuse Assessment ☐ _______ Attendance/ Progress Report ☐ _______ Immunization Records ☐ _______ Billing Information ☐ _______ Service Plan (non-clinical)

***I give permission for the exchange of any and all information required for these purposes, including but not limited to grades, personal information, attendance, test scores, date and place of birth, schools attended, tribal affiliation, educational barriers, applicable community agencies and other information through Zangle and other resources between CITC and ASD, and within CITC. This exchange is permissible until this release expires, even if I am no longer a student of ASD or client of CITC. I understand that I may request a copy of the records being released at any time. ______ (initials)**

I understand that I can refuse to authorize the release of any personal health information (PHI). I am not required to release PHI in order to ensure health care treatment, payment, enrollment, or eligibility for health care benefits. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that the information released may include information regarding Psychiatric Treatment (except psychotherapy notes), Substance Abuse Treatment/Rehabilitation, Medical Treatment, and HIV status. I give specific authorization for these records to be used and disclosed. If I have questions about disclosure of my health information, I can contact the CITC Privacy Officer at 907-793-3403.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to CITC for PHI records, and by telephone for substance abuse treatment records. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
Unless otherwise revoked, this authorization will expire on the following date : ________________________
If this space is left blank, this authorization will be presumed to expire two (2) years after the signature date below.

I understand that my alcohol and/or drug treatment records (if any) are protected under the Health Insurance Portability Accountability Act of 1996 (HIPAA), and Federal Regulations relating to HIPAA, 45 CFR Parts 160 and 164, and that, depending on the nature of the record and treatment involved, my records may also be protected under the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2. I understand that health information released, if covered by 42 CFR Part 2 (alcohol and drug abuse records), will continue to be protected by law from redisclosure once it leaves CITC. However, if the information is covered only by HIPAA, it is subject to redisclosure by the recipient and may no longer be protected. I understand that my records cannot be disclosed by CITC beyond what is permitted under this authorization without my written consent, unless provided for by the regulations.

☐ _____ **Check if information being disclosed is subject to 42 CFR part 2 (alcohol and substance abuse treatment).**
NOTICE TO RECIPIENT – PROHIBITION ON REDISCLOSURE IF BOX IS CHECKED: This information has been disclosed to you from records that may be 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 the 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.

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, and that I consent to its terms knowingly and voluntarily.

____ _______/______/______
Signature Date

_____________________________________ _________________________ ______/______/_______
Signature of Guardian/Parent/Authorized Person Relationship to Client Date

___________________________ _________________________________ _______/______/______
Printed Name Witness Date

Signed copy received by client: ☐ _____ **Yes** ☐ _____ **No, client declined copy**

For CITC Use Protected Health Information Only:

Alternative Communication Request: ☐ Accepted ☐Denied
Comments:
____
____
____
____

Privacy Official's Signature: ____ Date: ______________________________

Continued from Page One - Billing Entities potentially receiving information: AETNA; Affiliated Computer Services, Inc (Medicaid); AK Pipe Trade Local 367 Health and Security; AK Electrical Health and Welfare Fund; AK HERE Health and Welfare Trust; AK Rural Employee Benefit Trust; Alaska Labors; Alaska U.C.F.W.Trust; Ameriben/IEC Group; ASEA/AFSCME Local 52 Health Benefits Trust; Blue Cross Blue Shield; Chanylut; First Choice Health PPO Plan; Great West Health Care; Health and Welfare Benefits System; Healthcomp; Meritain Health; ODS Select Network Group; PGBA/Tricare; Principal Financial Group; Providence Health Plan; PS5 Health Plan Solutions; Risk Benefits Management Services; Salvation Army; SO AK Carpenters Health & Security Plan; SOA Office of Children's Services; American Postal Workers Union Health Plan; Zenith Administrators

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Authorization to Use or Disclose Psychotherapy Notes

1. Client's Name: ______________________________ DOB: _________________ Last Four Digits of SSN: ___________

I (______ Client _______ Parent _______ Legal Guardian) hereby authorize Cook Inlet Tribal Council (CITC) to:
☐ _______ **Release protected health information within and among CITC departments and to:**
☐ _______ **Obtain information from:**

Name: ______________________________________ ____
(Facility, Organization, or Individual Name)

Address: ____ Phone/Fax: _________________________________

The following forms of information: ☐ _______ **written** ☐ _______ **verbal** ☐ _______ **all available records**

2. The purpose of this use or disclosure is: ☐ at my request ☐ Other (Please describe): ________________________

Information To Be Used or Disclosed Includes Psychotherapy Notes, subject to the following:

3. Defined in CFR 45 Section 164.501, Psychotherapy Notes means notes recorded (in any medium) by a mental health professional documenting or analyzing the subject matter of conversation during a private individual, group, joint or family counseling session. Psychotherapy notes are separate from the rest of the individual's medical or mental health record.

4. I understand that I have a right to revoke this authorization at any time. I understand that I must provide revocation in writing to CITC. I understand that the revocation will not apply to information that has already been used or disclosed. I understand that the revocation will not apply to my insurance company when the law provides my insurers with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire: ☐ on (date)_________ Not to exceed 90 days if to financial institution or employer for purposes other than payment; or ☐ when the following event related to the patient or purpose of disclosure occurs __________________________. If no date is specified, this authorization will expire one year from the date of execution.

5. I understand that I may refuse to sign this authorization. I am not required to sign this authorization in order to receive treatment, payment, enrollment or eligibility for benefits. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal or state confidentiality rules. If I have questions about disclosure of my health information, I can contact Health Information Services.

6. I understand that my alcohol and/or drug treatment records (if any) are protected under the Health Insurance Portability Accountability Act of 1996 (HIPAA), and Federal Regulations relating to HIPAA, 45 CFR parts 160 and 164, and that, depending on the nature of the record and treatment involved, my records may also be protected under the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR part 2. I understand that health information released, if covered by 42 CFR Part 2 (alcohol and drug abuse records), will continue to be protected by law from redisclosure, except as expressly permitted by this authorization. However, if the information is covered only by HIPAA, it is subject to redisclosure by the recipient and may no longer be protected. I understand that my records cannot be disclosed by CITC beyond what is permitted under this authorization without my written consent, unless provided for by the regulations.

COULD YOU BE ENDANGERED BY THE DISCLOSURE OF ALL OR PART OF THE INFORMATION TO WHICH THIS REQUEST PERTAINS ? ☐ _______ **Yes** ☐ _______ **No**

_______ initials

I authorize the use or disclosure of my psychotherapy notes as depicted above. 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, and that I consent to its terms knowingly and voluntarily.

____ _______/______/______
Signature Date

___________________________ __________________ ______/______/______
Signature of Guardian/Parent/Authorized Person Relationship to Client Date

____________________ ________________________ _______/______/______
Printed Name Witness Date

Signed copy received by client: ☐ _____ **Yes** ☐ _____ **No, client declined copy**

☐ _____ **Check if information being disclosed is subject to 42 CFR part 2 (alcohol and substance abuse treatment).**
NOTICE TO RECIPIENT – PROHIBITION ON REDISCLOSURE IF BOX IS CHECKED: This information has been disclosed to you from records that may be 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 the 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.

For CITC Use Only:

Alternative Communication Request: ☐ Accepted ☐ Denied

Comments:
____
____
____
____
____
____

Privacy Official's Signature: ______________________________ Date: ________________________

Date

Notes about use of this psychotherapy authorization form:

- Section 164.508(a)(2) requires an authorization for the use or disclosure of psychotherapy notes, except: Disclosures to the Secretary (as permitted in 164.502); Disclosures when authorization is not required as follows: By law (164.512(a)); With respect to the oversight of the originator of the psychotherapy notes (164.512(d)); About decedents (164.512(g)); To avert serious threat to health or safety (164.512(j))
- Section 164.508(b)(3) does not allow an authorization for psychotherapy notes to be combined with an authorization for other types of health care information, therefore, this is a separate authorization for psychotherapy notes only.