KENAITZE INDIAN TRIBE HEALTH SERVICES
AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL HEALTH INFORMATION

Records needed for continuing medical care are provided free; there may be a charge for other requests.

Authorization for Release of Confidential Health Information is specific to the following KIT Program:

☐ Medical ☐ Dental ☐ Behavioral Health ☐ Chemical Dependency ☐ School Based

Name of Patient/Client (Last, First, MI)	Date of Birth	Previous or Other Names used
Address	City, State, Zip	Telephone # Alternate #

REQUESTOR MUST PROVIDE A LEGIBLE COPY OF LEGAL IDENTIFICATION ALONG WITH THIS FORM

The information is to be disclosed by:		**And is to be released to:**	
Name of KIT Agency/Department **Dena'ina Wellness Center**		Name of Individual Receiving Records	
Address **508 Upland Street**		Agency Name and Address	
City, State, Zip **Kenai, AK 99611**		City, State, Zip	
Phone # **907-335-7500**	Fax # **888-490-2368**	Phone #	Fax #

I authorize the communication to be exchanged in/by: ☐ Writing ☐ Verbally ☐ Electronically ☐ Fax

I authorize the use/disclosure of health information about the above name individual/entity as described below for the following dates and purposes:

From _____ to _____

☐ Only information related to (Specify injury, accident or particular illness/treatment):_____

☐ Entire record for all dates of service.

☐ Billing statements for the following dates/treatment: _____

☐ Other information specified below.

Description of specific, including sensitive, information to be disclosed, please initial all applicable box(s) below:

	Medical Records		Program Attendance/Compliance		Psychological/Psychiatric Assessment
	Lab / Pathology Reports		Substance Abuse Assessment		Discharge Summary, Plan, Status
	Radiology Reports		Mental Health Assessment		Diagnosis
	Medication list		Treatment Plan/Recommendations		School Performance/Records
	Dental /History /X-Ray		Sexually Transmitted Disease		HIV Infection/AIDS

The information will be disclosed for the following purposes **(REQUESTOR MUST CHOOSE ONE OF THE FOLLOWING):**

☐ Customer Transferring Care to Other Hospital/Clinic ☐ Attorney ☐ Insurance ☐ Disability ☐ Military ☐ At the request of the individual or Personal Representative

For Court Ordered Individuals:

____ (initials) I understand this Release of Information is a condition of my treatment and services will not be provided should I refuse to sign.

I understand that my records are protected under HIPAA and may also be further protected under 42 CFR, Part 2(substance abuse diagnosis or treatment related records). I understand these records cannot be disclosed without my written consent, unless otherwise provided for by law, and that in most cases (see exception for court ordered participation), KIT cannot condition my treatment, enrollment in a health plan, or eligibility for health care benefits on my failure to sign the authorization. I am aware that, but for records protected under 42 CFR Part 2, there is a potential that records disclosed under this authorization are subject to re-disclosure and are no longer protected under HIPAA. I am aware that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires:

_____ One year from date signed, or: _____

Signature of Individual: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Signature of Witness: _____ Date: _____

This information has been disclosed to you from records protected by Federal Confidentiality Rules, including HIPAA and potentially 42 CFR Part 2). If these records are governed by 42 CFR Part 2, you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains to 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 client.

Verification of Identity and Authority

Form of Identification: _____ Date Received: _____

Documentation of Authority _____

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

Instructions for Completing Kenaitze Indian Tribe Health Services
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. Print legibly in all fields using dark permanent ink. Incomplete information may cause a delay in the process.
2. Print your legal name or the legal name of the individual whose information is to be released.
3. Print the name, address and phone number of the facility releasing the information.
4. Provide the name of the person, agency name, address and phone number that will receive the information.
5. Provide a reason why the information is required, e.g. disability claim, continuing medical care, legal, etc.
6. If a *different* expiration date is desired, specify a new date. The date cannot extend past one year.
7. A copy of this completed *Authorization to Release Information* form will be provided to you.
8. Please note: Release of Records is usually processed and completed within 10 working days. However, the process may take longer if your records have been archived. Requests are responded to in the order received.

Revocation of Consent for Release of Confidential Information

I, _____, hereby revoke the authorization to release information I provided to Kenaitze Indian Tribe Health Services (Dena'ina Health Clinic, Dena'ina Dental Clinic, and Nakenu Family Center) 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 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.

_____

_____

_____

Full Name (printed)	Signature	Date
Personnel Name	Personnel Signature	Date
Program Director Name	Program Director Signature	Date