Anchorage Community Mental Health Services, Inc. /Fairbanks Community Mental Health Services, LLC.
Authorization to Release Health Information

☐ Folker – Main Center - Adult Services | 4020 Folker Street Anchorage, AK 99508 | Ph. 907.563.1000 Fax 907.375.3115
☐ Family Services – On Target - PLL – AK Child Trauma Ctr – Little Tykes - AYA | 4045 Lake Otis Pkwy STE 101 | Anchorage, AK 99501 | Ph. 907.561.0954 Fax 907.375.3115
☐ Ingra Adult Services – IDP – Housing & Engaging Svs. |1432 Ingra Street | Anchorage, AK 99501 | Ph. 907.562.7900 Fax 907.375.3115
☐ FCMHS – Fairbanks |1423 Peger Road | Fairbanks, AK 99709 | Ph. 907.371.1300 Fax 907.371.1386

Name_____**DOB**:_____**SSN**:_____
(Name of client whose information is being released) (Optional)

Previous Name(s) _____
(List any and all)

I, ____ Client ____ Parent ____ Legal Guardian hereby authorize

☐**ANCHORAGE COMMUNITY MENTAL HEALTH SERVICES or** ☐**Fairbanks Community Mental Health Services to:**
☐**Release Information To:** ☐ **Obtain Information From:**

Name: _____**Phone#**_____

Address: _____**Fax#**_____

The following information: ☐**written** ☐**verbal**

PURPOSE OF INFORMATION (**Include client/parent/guardian initials**)		INFORMATION TO BE RELEASED / REQUESTED	
☐ ____Treatment Planning	☐ ____Personal Use	☐ Admissions/Intake Summary	☐ Lab Results
☐ ____Continued Treatment	☐ ____Legal Use	☐ Discharge Summary	☐ Substance abuse Tx
☐ ____Coordinate Treatment		☐ Treatment/Safety Plan	☐ Medication Records
☐ ____Benefits/Supports		☐ Psychiatric Evaluation	☐ Videography
☐ ____Other (Specify) _____		☐ Medical Progress Notes	☐ Other (Specify)_____
_____		☐ Clinical Progress Notes	
		☐ Case Management Notes	**Date Range**_____**to**_____

- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I understand that I may inspect or copy the information to be used or disclosed, as provided in 45CFR 164.524, 42CFR Part 2.
- I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.
- I understand that the information released may include information regarding Psychiatric Treatment, Substance Abuse Treatment and/or HIV. If I have questions about disclosure of my health information, I can contact ACMHS Clinical Records at 563.1000.
- 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 ACMHS Clinical Records at 563.1000.
- 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.
- I understand and agree to pay the costs incurred by ACMHS in preparing a copy of records I may request for myself as allowed by State and Federal guidelines.

_____ **By initialing this section I am allowing the information to be disclosed one time. This authorization will expire 90 days from the date of my signature, unless otherwise indicated or revoked.**

Unless otherwise indicated or revoked this **authorization will expire 1 year from my signature date or in**: _____ days. (must be less than 12 months)

_____ _____
Client Signature (Required for ANY substance use release) **Date**

_____ _____ _____ _____
Relative/Guardian/Authorized Person **Printed Name** **Relationship to Client** **Date**

_____ _____
Witness **Date**

Copy must be offered to client: ____ **Accepted** ____**Refused**

SERVICE PROVIDER TO COMPLETE THIS SECTION

ACTION TO BE TAKEN:
☐ Send For Records ☐ Send ROI Only ☐ Release ACMHS/FCMHS Records ☐ File ROI Only