CHUGACHMIUT
AUTHORIZATION FOR DISCLOSURE OF SUBSTANCE USE DISORDER RECORDS

Patient Name: _____ Date of Birth:_____

Patient Address: _____

Phone #: _____

RECIPIENT

I authorize Chugachmiut to use/disclose my substance use disorder records as described below to the following individual(s) or organization(s) (name or title of the recipient):

_____

PURPOSE OF USE/DISCLOSURE

The information may be used/disclosed by Chugachmiut for the following purpose (be specific):

_____

If the recipient is a health care provider, health plan, or health care clearinghouse, and the disclosure is made for the purposes of treatment, payment, or health care operations, the disclosed records may be redisclosed in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against the patient.

FORM OF INFORMATION

☐ I authorize Chugachmiut to disclose copies of my records as described in this form.

☐ I authorize Chugachmiut and its staff to discuss my care with the recipients identified in this form.

TYPE OF INFORMATION

DATE RANGE:_____TO_____

I authorize disclosure of the following substance use disorder records (please initial):

_____	Acknowledge attendance in treatment	_____	Substance abuse assessment
_____	History pertinent to this referral	_____	Program compliance
_____	Diagnosis	_____	Prognosis
_____	Urinalysis results	_____	Psychological/Psychiatric assessment
_____	Treatment plan	_____	Psychological/Psychiatric reports
_____	Treatment records	_____	Medical Records
_____	Discharge summary, Status	_____	Other: _____
_____	Treatment recommendations		

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LENGTH OF AUTHORIZATION

Unless revoked, this authorization expires on: _____
This time period must be no longer than reasonably necessary to serve the purpose of the disclosure. If left blank, this authorization will expire six months from the date of the patient's signature.

APPLICABLE LAW

By signing this authorization form, I understand and agree that:

- My substance use disorder records are protected under the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and HIPAA. Each disclosure of my records made with my consent will be accompanied by a copy of my authorization form, or a clear explanation of the scope of the consent provided, and a statement regarding the limitations on unauthorized use or disclosure of the records. 42 C.F.R. § 2.32.

- I may revoke this authorization in writing at any time by notifying Chugachmiut, except to the extent that Chugachmiut has already used or disclosed information in reliance on my authorization.

- I will not be denied services if I refuse to consent to disclosure for treatment, payment, or health care operations, unless such disclosure is necessary for Chugachmiut's proper treatment of me, obtaining payment for my services, or its health care operations.

SIGNATURE

_____ _____
Signature of Patient *(Including if Patient is a Minor)* Date

_____ _____
Signature of Parent or Personal Representative Date
(Where Required or Authorized to Consent Under 42 C.F.R. § 2.14 or § 2.15)

_____
Printed name of Parent or Personal Representative (if applicable)

_____
Description of Personal Representative's Authority (if applicable)

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For Chugachmiut's Use Only:

Date Received:_____

Name/Title of Staff Member Processing Request: _____