Chugachmiut Behavioral Health
1840 Bragaw Street, Suite 110
Anchorage, AK 99508
Phone: (907) 562-4155 Fax: (907) 278-0300

Welcome to Behavioral Health Services!

Our Behavioral Health program provides treatment services for those who have concerns about emotional health, family problems, and substance use issues. Our trained person-centered providers can assist with relationship problems, parenting issues, and a range of other concerns like depression and anxiety.

Program services may include screenings, assessments, treatment planning, life skills development, mental health counseling, substance use treatment, case management, recovery camp, group therapy, and referral for medication when needed.

Please fill out the attached forms: 1) Notice of Privacy Practices, 2) Consent for Treatment & Billing, 3) Client Information, 4) Intake Questionnaire, 5) Alaska Screening Tool, 6) Client Status Review.

Also, your counselor will discuss safety plans (exits, fire extinguishers, and first aid kits) with you to ensure your safety while you are in our facilities. Weapons or other dangerous objects, illegal drugs, and medications not prescribed to the client are not permitted at the clinics. Chugachmiut reserves the right to search the client and to confiscate such objects upon reasonable probable cause. The clinics' obligation to provide a safe environment for care must override the individual's right to privacy.

The clinics reserve the right to place restrictions on any services due to unsafe behaviors and/or attitudes. Chugachmiut may reinstate access to programs if identified behaviors and/ or attitudes have discontinued, and it is deemed safe to resume services.

Your counselor will complete an assessment and develop a treatment plan with you to meet your personal goals. Should a situation arise where the therapist-client relationship in not conducive to therapy or where the behavioral health clinic is not equipped to handle your situation, a Behavioral Health staff will immediately refer you elsewhere for adequate, mutually agreed upon treatment. It is understood that you are voluntarily seeking services from Chugachmiut and that both you and Chugachmiut have the right to terminate program services at any time by simply notifying the other party of this intention. Chugachmiut will make appropriate referrals on its part.

We are delighted to introduce you to our treatment services. Always remember that these are your services, so your participation in all aspects (such as setting goals and attending sessions) is vital to the counseling process. Chugachmiut has served the region for fifty years. The organization has witnessed growth in both the communities and the individuals who live in the Chugach region. Please see our brochure for additional information. If you have any questions, please let our staff know.

For 24-hour assistance, you can call the Crisis Line at (907) 891–0444.

Your Chugachmiut Behavioral Health Staff

CHUGACHMIUT
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ AND REVIEW IT CAREFULLY.

This notice applies to records of services that are provided by Chugachmiut Health and Behavioral Health Services.

Chugachmiut respects your privacy and understands that your health information is a private and sensitive matter. We make a record of the care and services you receive at Chugachmiut which is called your protected health information (PHI). This information is needed to give you quality health care and comply with the law. For example, this information includes your symptoms, test results, diagnosis, treatment, health information from Chugachmiut and other health care providers, and billing and payment information related to those services. We will not disclose your information to others unless you authorize us to do so, or unless the law authorizes or requires us to do so.

This privacy notice will tell you about: (1) the way that we may use and disclose PHI about you; (2) your privacy rights; and (3) special rules for patients of Chugachmiut's substance use disorder (SUD) treatment programs; and (4) Chugachmiut's responsibilities in using and disclosing your PHI.

WHO WILL FOLLOW THIS NOTICE:

- Any staff or other individuals authorized by Chugachmiut to access, handle, or enter information into your health record; or
- Any member of a volunteer group we allow to help you while you are receiving services at Chugachmiut;

CHUGACHMIUT'S RESPONSIBILITIES:

We are required by law to:

- Keep your PHI private;
- Provide you with this Notice of our legal duties and privacy practices with respect to PHI;
- Notify you of your specific rights as to PHI which includes substance use disorder records and is subject to 42 C.F.R. Part 2;
- Notify affected individuals following a breach of unsecured PHI;
- Follow the terms of the Notice of Privacy Practices currently in effect.

We have the right to change our practices regarding the PHI we create or maintain. If we make changes, we will update this Notice. You may obtain the most recent copy of this Notice by

calling, visiting any of our Chugachmiut programs and asking for it, or by visiting our website: www.Chugachmiut.org.

HOW CHUGACHMIUT MAY USE & DISCLOSE YOUR PHI:

The following is an explanation of some of the ways your PHI may be used and disclosed:

Treatment: We use your PHI for treatment purposes. Information obtained by our health care staff will be recorded in your health record and used to help decide appropriate care. We may also provide information to other individuals or entities providing your care. For example, Chugachmiut may share your medication information with a specialist that we refer you to in order to avoid treatment that might cause a negative reaction with your medication.

Payment: We use your PHI for payment purposes. "Payment" includes the activities of Chugachmiut to obtain payment or be reimbursed for the services we provide to you. For example, insurance companies may need information about services you received at a Chugachmiut clinic in order to authorize payment. In addition, if someone else is responsible for your health care costs, we may disclose information to that person about services we provided to you when we seek payment.

Health Care Operations: We use your PHI for health care operations. "Health care operations" are certain administrative, financial, legal and quality improvement activities necessary to run Chugachmiut's clinics and programs and make sure all patients receive quality care. For example, we may use your PHI to evaluate the performance of our staff, or to evaluate services provided at Chugachmiut.

Electronic Health Information Systems: We utilize electronic health information systems, including an integrated multi-facility electronic health information systems with a patient service communications network that permits providers involved in your care at other tribal health care facilities, and the Indian Health Service, to access health information accumulated about you at our facilities. Once information is entered into many of these systems, it can be amended, but it cannot be removed. Once a user is authorized to have access to your information contained in some of these systems, the user will continue to have such access until determined otherwise. We may make your protected health information available electronically through an electronic health information exchange to other health care providers and health plans that request your information for their treatment and payment purposes. Participation in an electronic health information exchange also lets us see their information about you for our treatment and payment and healthcare operation purposes. You are permitted to request and review documentation regarding who has accessed your information through the electronic health information exchange. You also may "opt out" of including some or all of your health information in the exchange. If you opt out, then your information will only be available to providers who use the Alaska Tribal Health System's shared electronic health record. Your provider will have information on how to make this request, or you may find the information on our website, once we begin participating in the exchange.

Appointment Reminders: We may use and disclose PHI to contact you as a reminder that you have an appointment for treatment or health care at Chugachmiut. We may use and disclose health care information during the reminder call, but the information disclosed will be kept to what is necessary to remind you of the appointment.

Interpreters: In order to provide you proper care and services, we may use the services of an interpreter. This may require the use or disclosures of your PHI to the interpreter or others facilitating the provision of interpreter services.

Other Treatments and/or Health Products: We may use and disclose your PHI to tell you about treatment options or alternatives or about health-related products or services that may be of interest to you.

Research: Under certain circumstances, we may use and disclose PHI about you for research purposes, both with and without your permission. Before we disclose your PHI without your permission, we verify that researchers meet specific requirements under HIPAA to protect your PHI, and if appropriate, obtain approval from authorized body that ensure the protection of human research subjects. .

Funeral Directors/Coroners/State Medical Examiner: We will disclose PHI about you to funeral directors, coroners and the state medical examiner, consistent with applicable law to allow them to carry out their duties.

***Public Health Risks*:** We may disclose your PHI for public health activities that can include the following:

- Prevention or control of disease, injury or disability;
- Reports of births and deaths;
- Reports of abuse or neglect of children, elders and dependent adults;
- Reports of reactions or problems with medications or health products;
- Notifying people of product recalls related to their health care;
- Notifying a person that they may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

Workers' Compensation Laws: We will disclose your PHI when required by state law and/or when you have made a workers' compensation claim that provides benefits for work-related injuries or illness.

Correctional Institutions: If you are in jail or prison, we may disclose your PHI to the Department of Corrections for your health and the health and safety of others.

Law Enforcement: We may disclose PHI about you to law enforcement for certain purposes, such as to report criminal conduct that occurred on our premises, to locate you when you are the suspect of a crime, to avert a serious and imminent threat to health or safety, or when

required by law such as to report certain injuries caused by guns or knives, or by a subpoena, court order or other legal process.

Tissue Donation, Organ Procurement and Transplant: We may disclose your PHI to organizations that handle organ procurement or tissue transplantation or to an organ donation bank, to help with organ or tissue donation and transplant, if you or your family members agree.

***Health and Safety Oversight*:** We will disclose your PHI to a health oversight agency when required by law. These oversight activities include audits, investigations and medical licensure.

Preventing a Serious and Imminent Threat: We may use or disclose your PHI if we believe in good faith that it is necessary to prevent or lesson a serious and imminent threat to the health and safety of a person or of the public. Disclosure may be to a person reasonably able to prevent or lessen the threat, including a friend, family member, employer, provider, or law enforcement.

Disaster Relief Purposes: We may disclose your PHI to disaster relief agencies or law enforcement to assist in notification of your condition to family or others in case of a disaster.

Military and Veterans: If you are a member of the armed forces, Chugachmiut may release your PHI as required by military command authorities.

Court Orders, Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a warrant, subpoena, court or administrative order in accordance with applicable law.

National Security and Intelligence Activities: We may release your PHI to authorized federal officials for intelligence, counter intelligence and other national security activities authorized by law.

Business Associate Agreements: We may disclose your PHI to individuals and organizations that assist Chugachmiut with treatment, health care operations or payment purposes. For example, Chugachmiut may disclose PHI to consultants or attorneys who assist us in complying with our legal obligations. These business associates must agree to protect the confidentiality of PHI.

- ***Other Uses and Disclosures:*** We may also use and disclose your PHI as specifically required or authorized by applicable laws for other reasons not specifically listed here.

Notification of Family and Others: Unless you object, we may release PHI about you to a friend or family member who is involved in your health care, or payment for care, while you are receiving services, if determined appropriate under the circumstances. In emergency cases where you are unavailable or incapacitated, or do not otherwise object, we may also tell your family or friends your location and general condition. If you would like to restrict the PHI

provided to family or friends involved in your care or payment for care, please contact the Privacy Officer at number at the end of this notice.

If you want a family member or friend to be able to access information about you or assist in arranging your health care, such as scheduling or checking on appointment times, please make sure that an authorization is on file for that person to access your records. This will be required for individuals to assist you in this manner.

Uses and Disclosures That Require Your Authorization: Other than the uses and disclosures described above, PHI will be used or disclosed only as allowed or required by law, or with your written authorization. For example, uses or disclosures made for the purpose of marketing or the sale of PHI require your authorization. You have the right to revoke an authorization at any time, except where we have otherwise relied on the authorization or the law prohibits revocation.

SPECIAL RULES FOR SUBSTANCE USE DISORDER PATIENT RECORDS

If you receive substance use disorder (SUD) treatment services, whether at Chugachmiut or another facility, PHI that identifies you as receiving SUD services may be protected not only by HIPAA, but also by federal confidentiality regulations at 42 C.F.R. Part 2 ("Part 2"). Part 2 provides additional safeguards to protect the privacy of your PHI. Not all PHI discussing an SUD or SUD services is protected by Part 2. Chugachmiut will determine whether Part 2 applies to your PHI.

In general, Chugachmiut must obtain your written consent before disclosing PHI protected by Part 2 outside of Chugachmiut or to providers that are not part of your SUD treatment team. Chugachmiut may condition SUD treatment on receiving your consent to disclosure for payment purposes. However, Part 2 permits Chugachmiut to release your PHI subject to Part 2 without your consent in certain circumstances, including:

- Pursuant to an agreement between Chugachmiut and a qualified service organization or business associate which provides health care operational services to Chugachmiut;
- For research, audit or evaluation purposes:
- To report a crime against Chugachmiut personnel or on Chugachmiut property;
- To medical personnel in a medical emergency;
- To report suspected child abuse or neglect to appropriate authorities; and
- Pursuant to a court order.

In other situations not listed here, we will obtain your consent before disclosure.

YOUR INDIVIDUAL RIGHTS REGARDING YOUR PHI

The health and billing records we make and store belong to Chugachmiut. The PHI in the records, however, generally belongs to you. You have specific individual rights as to the uses and disclosures of your protected health information, as follows:

***Notice*:** You have the right to receive a copy of this Notice.

***Questions*:** You have the right to ask questions about any information contained in this Notice.

***Right to Request Restrictions on Use*:** You have the right to ask Chugachmiut to limit certain uses and disclosures of your PHI. If you want to limit a use and disclosure, you must submit the request in writing. We are not required to grant the request except under special circumstances, such as a restriction on information provided to an insurer for services paid for out-of-pocket. If we grant your request, we will inform you and comply with it unless the PHI is needed to provide emergency services.

***Right to Request Confidential Communications*:** You may request that Chugachmiut communicate with or contact you by a particular means (mail, e-mail, fax, etc.) or at a particular location. These requests must be made in writing and we have a form available for this type of request. Chugachmiut will accommodate reasonable requests.

***Right to Request An Inspection and Receive Copies*:** You may request to see and/or get a copy of your PHI. If your PHI is in electronic format, you may request that your copy also be in electronic format, and Chugachmiut will comply if the requested electronic format is reasonably available.

***Right to Request An Amendment to Your Record*:** You have the right to request amendment to your PHI, which must be submitted to us in writing. The right to request amendment of your record does not include the right to have your records destroyed. If we agree to your request, we will amend your record. If we deny your request, we will inform you in writing, and you may submit a statement of disagreement that will be stored in your health record. Please note that we may add our own statement disagreeing with your proposed changes. All statements regarding amendments to your PHI will be included with any release of your PHI.

***Revoke or Cancel Prior Authorizations*:** If you provided us authorization to use or disclose your PHI, you may revoke your authorization in writing at any time. Once revoked, we will no longer use or disclose your PHI for the reasons covered by your written authorization. However, we are unable to take back any disclosures we have already made with your permission, and if the authorization was obtained as a condition of obtaining insurance coverage, applicable law may prohibit you from revoking your authorization.

***Right to Know About Disclosures*:** You have the right to request a list (an "accounting") of certain disclosures of your PHI made by Chugachmiut, for up to a period of six years following disclosures of hard copy PHI, and for a period of three years following disclosures of electronic PHI. This list will not include disclosures to third party payers, or disclosures for treatment or health care operations purposes. Other exceptions to the accounting requirement include, but are not limited to, disclosures made subject to your right of access, to individuals involved in your care, for national security purposes, and for the health and safety of inmates or detainees.

You may request an accounting at any time. Chugachmiut is only required by law to provide one accounting without charge during any 12-month period. We will notify you of the cost involved if you request this information more than once in a 12-month period.

***Right to be Notified of a Breach*:** In the event of a breach of the privacy or security of your PHI, Chugachmiut will notify you of regarding the circumstances of the breach, efforts that Chugachmiut has taken to correct or mitigate the breach, and steps you can take to protect yourself from potential harm.

***No Right to Certain Information*:** There is certain information to which you do not have a right to access. Specifically, you do not have a right to access psychotherapy notes regarding your care, any information prepared for a legal proceeding, or any information that might have other legal restrictions against disclosure. If Chugachmiut refuses to give you access to certain information, you may request that Chugachmiut provide you with information on your appeal rights, if any.

TO ASK FOR HELP, EXPRESS A CONCERN OR COMPLAINT

If you have questions, want more information or want to report a problem about the handling of your PHI, or file a written complaint because you believe your privacy rights have been violated, you may contact:

Privacy Officer
c/o Chugachmiut Health Services
201 3rd Avenue, Suite 201
Seward, AK 99664
1-800-224-3076

For general PHI, you may also file a written complaint with the Office of Civil Rights online at hhs.gov/hipaa or at:

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue. S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Violation of the protections established by 42 C.F.R. Part 2 for substance use disorder patient records is a crime. You may file a complaint regarding a violation with the U.S. Attorney's Office in Anchorage, reachable by mail at 222 West 7th Ave., Room 253 #9, Anchorage, AK 99513, or by phone at (907) 271-5071.

Chugachmiut will not, and is prohibited from, retaliating or discriminating against you due to reports you've made to us or the federal government regarding your privacy rights.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Effective Date April 14, 2003, Revised November 8, 2021

Chugachmiut's Notice of Privacy Practices provides information about how Chugachmiut may use and disclose protected your PHI. You have the right to review the Notice before signing this acknowledgement. As stated in the Notice, the terms of the notice may change. If the Notice is changed, you may obtain a revised copy by contacting the Privacy Officer or asking any Chugachmiut health service team member.

By signing this form, you acknowledge receipt of Chugachmiut's Notice of Privacy Practices, and have had sufficient opportunity to review its contents and ask any questions of Chugachmiut.

_____
Date

_____ _____
Printed Name of Patient Printed Name of Authorized Representative

_____
Signature of Patient or Authorized Representative

MY CONSENT FOR HEALTH SERVICES TREATMENT AND BILLING

I consent to treatment which may be performed during the visit and for ongoing health care as a patient of Chugachmiut, including emergency treatment of services, which may include, but are not limited to: laboratory procedures, x-ray examinations, medical and/or surgical treatment and/or procedures, anesthesia and/or medical services rendered under the general and special instructions of the patient's physician, healthcare provider or surgeon.

I understand that:

A) It is customary, except in emergencies or unusual circumstance, that major procedures are not carried out until the patient has discussed them with the physician or other health professionals and has agreed to the procedure(s);
B) Each patient has the right to refuse any proposed procedure(s) and/or treatment(s);
C) No patient will be involved in any research or experimental procedure(s) without his/her full knowledge and consent; and
D) I understand that no guarantee has been made to me as to the result or cures that may obtained from examination or treatment.
E) I understand that Chugachmiut is a teaching facility and that resident physicians "physician in training", medical students, nursing students and other health professional students may be involved in my care. I recognize that these residents and students are supervised by experienced staff. My primary physician and/or healthcare provider have full authority and responsibility for my care. I understand I may refuse care by any resident or students at any time, and that such refusal will not result in any reduction of the quality of care provided.

In the event that a healthcare worker has an exposure to my blood or body fluids during the course of my care at Chugachmiut, I hereby give my consent to be tested for the presence of communicable diseases that may cause risk to the healthcare worker. The results of these tests will be retained with my confidential medical information. I will not be charges for the testing, and the results will be sent to my primary healthcare provider. I understand that testing will be done through Chugachmiut and that I may contact them with any questions or concerns regarding this issue.

FINANCIAL MATTERS

My Financial Obligation for Services Provided to Me

I understand payment in full is required within thirty (30) days of service. I may be asked to remit in full if my insurance has not paid within the time frame. I may make special payment arrangements if this creates a financial hardship by talking to a billing representative at the clinic or contacting the billing department at 907-334-0106. Should the account be referred to a collection agency or an attorney for collections, I understand I shall pay actual attorney fees and collection expenses.

Upon request, Chugachmiut will make a good faith effort to give the patient, guarantor, resident or client, an estimate of charges using the most current pricing for the same or similar services.

These estimates provide no guarantees or limitation to a person's actual billed charges due to the inability to predict all the services and equipment that may be required to comply with the individual plan of care.

My Authorization for Direct Payment of Insurance Benefits to Chugachmiut

I authorize, whether I sign as an agent or as a patient, direct payment to Chugachmiut any insurance benefits otherwise payable for services related to the visit and ongoing health care. It is understood that I am financially responsible for all charges not covered by this assignment including those that are excluded from coverage by my insurance carrier.

My Consent to Chugachmiut to Release Information

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize Chugachmiut to disclose portions of my record, including healthcare records, to any person and/or corporation which may be liable to pay for my clinic(s) services.

GENERAL INFORMATION Safe

Environment for Health Care

Weapons or other dangerous objects, illegal drugs, and drugs not prescribed to the patient, by the patient's physician or healthcare provider are not permitted at the clinic(s). The clinic's obligation to provide a safe environment for care must override the individual's right to privacy. Chugachmiut reserves the right to search the patient, guarantor, resident or clients and to confiscate such objects upon reasonable probable cause.

Personal Valuables

I understand that the clinic(s) have advised that I should leave my personal property, money, and valuables at home or with family/friends. I agree that the clinic(s) shall not be liable for any loss or damage to said personal property, money, or valuables and waive all such claims. I understand that the clinic(s) is not responsible for the safekeeping of my personal property, money, or valuables left by me in the clinic(s) public areas or in patient, resident or clients rooms.

By signing my signature, I acknowledge that I have read and understand MY CONSENT FOR HEALTH SERVICES TREATMENT AND BILLING regarding treatment for myself or if signing as a parent or guardian, for my minor child or the person for whom I am responsible.

Current Phone Number(s) Printed Patient Name Date of Birth

Signature of Patient Date

Signature of Guardian, Relative or Responsible Party Date

Chugachmiut

CLIENT INFORMATION FORM

Name: _____ Date: _____
(First, Middle, Last)

Address: _____
Address City State Zip Code

Home Phone: _____ Cell Phone: _____

May we leave a message at either of these numbers? _____

Email Address: _____

Social Security Number: _____ Date of Birth: _____

Medicaid Number: _____

Other Health Insurance: _____ Policy Number: _____

Emergency Contact: _____ Phone: _____

Relationship to You: _____

Occupation: _____

Religious/Spiritual Preferences: _____

Cultural Background: _____

Reason For Visit: _____

Demographics

Race:

- ☐ Aleut or Sugpiaq
- ☐ American Indian
- ☐ Asian
- ☐ Athabascan (Other than American Indian)
- ☐ Black/African American
- ☐ Caucasian or White
- ☐ Haida
- ☐ Inupiat
- ☐ Native Hawaiian
- ☐ Other Alaska Native
- ☐ Pacific Islander
- ☐ Tlingit
- ☐ Tsimshian
- ☐ Yupik
- ☐ Other

Ethnicity:

- ☐ Not Spanish/Hispanic/ Latino/Mexican
- ☐ Spanish/Hispanic/Latino
- ☐ Hispanic
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Mexican
- ☐ Chicano/Other Hispanic

Sex:

- ☐ Male
- ☐ Female
- ☐ Unknown
- ☐ No Response
- ☐ Female Becoming Male
- ☐ Female Formerly Male
- ☐ Male Becoming Female
- ☐ Male Formerly Female

Gender Identity:

- ☐ Woman
- ☐ Man
- ☐ Bigender
- ☐ Cisgender
- ☐ Gender Fluid
- ☐ Gender Neutral
- ☐ Gender Non-conforming
- ☐ Genderqueer
- ☐ Non-binary
- ☐ Other
- ☐ Transgender

Sexual Orientation:

- ☐ Aromantic
- ☐ Asexual
- ☐ Bisexual
- ☐ Gay
- ☐ Heterosexual
- ☐ Homosexual
- ☐ Lesbian
- ☐ Other
- ☐ Panromantic
- ☐ Pansexual
- ☐ Queer

Chugachmiut

Demographics Continued

Education:

- ☐ K-12, how many years? _____
- ☐ General Education Degree (GED)
- ☐ High School Diploma
- ☐ Vocational Training Beyond HS
- ☐ Special Education Ungraded Classes
- ☐ Undergraduate Work (no degree)
- ☐ Associate Degree
- ☐ Baccalaureate Degree (BA, BS)
- ☐ Graduate Work (no degree)
- ☐ Master's Degree
- ☐ Doctorate/Professional Degree
- ☐ Post-Secondary 1 Year
- ☐ Post-Secondary 2 Years
- ☐ Post-Secondary 3 Years
- ☐ Post-Secondary 4 Years
- ☐ Other
- ☐ No Schooling

Military Status:

- ☐ Never in Military
- ☐ Vietnam Era Veteran
- ☐ Gulf War Veteran
- ☐ Iraq War Veteran
- ☐ Afghan War Veteran
- ☐ Retired from Military
- ☐ Reserves or National Guard
- ☐ Veteran
- ☐ On Active Duty
- ☐ Military Dependent

Financial and Household Information

Employment Status:

- ☐ Disabled
- ☐ Full Time
- ☐ Part Time
- ☐ Homemaker
- ☐ Armed Forces
- ☐ No Response
- ☐ Not in Labor Force – Other
- ☐ Not Seeking Work
- ☐ Other
- ☐ Resident/Inmate
- ☐ Retired
- ☐ Seasonal Emp, In-Season
- ☐ Seasonal Emp, Out of Season
- ☐ Student
- ☐ Unemployed, Looking for Work
- ☐ Unemployed, Not Seeking Work
- ☐ Unemployed, Subsistence Lifestyle

Source of Income:

- ☐ None
- ☐ Alaska Native Corp Dividends
- ☐ Alimony
- ☐ Alaska PFD
- ☐ Child Support
- ☐ Employment
- ☐ Interest and other
- ☐ Other
- ☐ Public Assistance/Welfare Pay
- ☐ Parent's Income
- ☐ Railroad Retirement
- ☐ Retirement/Survivor/Disability Pension
- ☐ Social Security Disability (SSDI)
- ☐ Self-Employment
- ☐ Supplemental Security Ins (SSI)
- ☐ Spouse's or Significant Other's Income
- ☐ Social Security
- ☐ Unemployment Compensation
- ☐ Tribal Assistance Programs

Primary Payment Source:

- ☐ Aetna
- ☐ Moda Health
- ☐ Other government grant
- ☐ Other Native Health Care
- ☐ Other Private
- ☐ Other Public
- ☐ Unknown
- ☐ AK Native Health Care
- ☐ Worker's compensation
- ☐ Blue Cross/Blue Shields
- ☐ CIGNA
- ☐ HMO
- ☐ Indian Health Service
- ☐ Medicaid
- ☐ Medicare

Annual Household Income:

- ☐ $0 - $999
- ☐ $1,000 - $4,999
- ☐ $5,000 - $9,999
- ☐ $10,000 - $19,999
- ☐ $20, 000 - $29,999
- ☐ $30,000 - $39,999
- ☐ $40,000 - $49,999
- ☐ $50,000 and over

Health Insurance:

- ☐ None
- ☐ Blue Cross/Blue Shield (BCBS)
- ☐ Commercial
- ☐ Medicare Conditionally Primary
- ☐ Group Policy
- ☐ Health Maintenance Organization (HMO)
- ☐ Individual Policy
- ☐ Long Term Policy
- ☐ Litigation
- ☐ Medicare Part B
- ☐ Medicaid
- ☐ Medigap Part B
- ☐ Medicare Primary
- ☐ Other Government Service
- ☐ Other Public Insurance
- ☐ Other Private Insurance
- ☐ Other (e.g., TRICARE)
- ☐ Supplemental Policy
- ☐ VA Insurance
- ☐ Unknown

INTAKE QUESTIONNAIRE
ADULT/ADOLESCENT

In order for us to best serve you, it is helpful if we have some background information regarding your situation. Please answer all questions to the best of your knowledge. Any information provided will be kept confidential as outlined in the Privacy Policy.

Name: _____ Date: _____

Client Family History:

Your Birth Order *(Please Circle)*: 1 2 3 4 5 6 7 8 9 Other: ____

Current Marital Status: _____

Marital History (Number of marriages): _____

Current living situation? _____Excellent _____Good _____Fair _____Poor

If fair or poor, please explain: _____

_____

Number of people living in your home, including yourself: ____

Number of children living in your household: _____

Number of children living outside your household: _____

Status of family relationships: _____Excellent _____Good _____Fair _____Poor

If fair or poor, please explain: _____

_____

Client Medical History:

Current health status: _____Excellent _____Good ____Fair _____Poor

If fair or poor, please explain: _____

_____

Date of your last physical exam: _____

Name of health clinic/primary care physician:_____
Address: _____
Phone Number: _____

Do you have a medical advance directive on file? _____Yes _____No

If not, would you like to receive a referral to a medical provider who can help you set up a medical advance directive? _____Yes _____ No

Chugachmiut

Do you have a history of any of the following? *(Please mark all that apply):*

_____ Alcoholism
_____ Alzheimer's/Dementia
_____ Cancer
_____ Drug Abuse
_____ Heart Disease
_____ Heart Attack
_____ High Blood Pressure
_____ Learning Disability
_____ Pain Management
_____ Smoking, Vaping, Chewing Tobacco
_____ Thyroid Problems
_____ Other Chronic or Serious Health Problem:
_____
_____

Current prescribed medications for medical conditions:

Medication	Dosage	Date	Reason

Any known allergies to medications: _____

Use of complimentary health approaches (e.g., natural products, tai chi, meditation, massage):

_____

Any dental concerns: _____

Pregnant? _____Yes _____ No If yes, are you receiving prenatal care? _____ Yes _____ No

Do you have a need for assistive technology? _____ Yes _____ No

Childhood Health *(for children/adolescents ONLY):*

Are the child's immunizations up to date? _____Yes _____No

Speech functioning: ☐ Good ☐ Poor ☐ Absent
Hearing functioning: ☐ Good ☐ Poor ☐ Absent
Vision functioning: ☐ Good ☐ Poor ☐ Absent

Childhood Developmental History:

Client started school: _____Early *(Before age 5)* _____On Time *(Age 5)* _____Late *(After age 5)*

Please list any developmental delays you had in school: _____

Please list any learning difficulties you experienced: _____

Client Drug and Alcohol Use:

Have you ever used drugs or alcohol? _____Yes _____No
Date of first use: _____
Date of last use: _____

Substance	Frequency of Use	Amount	Length of Use	Age of First Use

Longest period of sobriety: _____

Prior stays for residential treatment for a substance abuse issue? _____Yes _____No

Substance abuse treatment location:

_____

History of Tobacco Use or Exposure:

Do you smoke tobacco? _____Yes _____No
Do you chew tobacco? _____Yes _____No
Do you vape/use e-cigs? _____Yes _____No

Are you exposed to secondhand smoke? _____Yes ____No

Client Mental Health History:

Have you previously received treatment for your mental health? _____Yes _____No

If yes, please indicate the reason: _____

Have you ever been diagnosed with any of the following?

_____Anxiety Disorders _____Attention-deficit/hyperactivity Disorders _____Bipolar Disorders
_____Depression Disorders _____Eating Disorders _____Trauma Disorders

Prior hospitalization for a mental health issue? _____ Yes _____No

If yes, on how many occasions? _____ Where? _____

Prior medications for treatment of mental health conditions? _____Yes _____No

If yes, please describe the effectiveness: _____

Current prescribed medications for mental health conditions:

Medication	Dosage	Length of Use	Effective?
			Y N
			Y N
			Y N
			Y N
			Y N

Client Current Emotional Health:

Please circle the number that best describes the severity of your problem.
0 = None 1 = Minor 2 = Moderate 3 = Significant 4 = Very Serious

Anxiety	0 1 2 3 4
Depression	0 1 2 3 4
Thoughts of death/suicide	0 1 2 3 4
Sleep problems	0 1 2 3 4
Mood swings	0 1 2 3 4
Grief	0 1 2 3 4
Physical abuse – current	0 1 2 3 4
Physical abuse – childhood	0 1 2 3 4
Sexual abuse or assaults	0 1 2 3 4
Marriage problems	0 1 2 3 4
Relationship problems with children	0 1 2 3 4
Problems with parents/extended family	0 1 2 3 4
Problems with work/school	0 1 2 3 4
Sexual problems	0 1 2 3 4

Appetite: _____ Poor _____ Fair _____ Good _____ Intense
_____ Binging (Overeating) _____ Purging (Vomiting)

Weight: _____ Stable _____ Loss _____ Gain

Sleep: _____ Number of hours/night _____ Restful _____ Restless

Experiencing: _____ Wake up frequently _____ Nightmares _____ Night terrors
_____ Repeating dreams _____ Repeating nightmares _____ Insomnia

Socialization: _____ Many active friendships _____ Few active friendships
_____ Little social contact

Do you feel you need more social support? _____ Yes _____ No

Client Legal History and Current Involvement:

Any current legal involvement? _____
_____

Legal history: _____
_____

Family Medical History:

Please list any significant medical history within your immediate and extended family (Mother/Father/Brothers/Sister/Spouse/Children):

_____
_____
_____

Family Mental Health History:

Please list any significant mental health history within your immediate and extended family (Mother/Father/Brothers/Sister/Spouse/Children):

_____
_____
_____

Has any family member ever attempted or completed suicide? _____ Yes _____ No

Has any family member ever experienced abuse, violence, neglect? _____ Yes _____ No

Family Substance Abuse History:

Please list any significant substance abuse history within your immediate and extended family (Mother/Father/Brothers/Sister/Spouse/Children):

_____
_____
_____

ALASKA SCREENING TOOL

Client Name: _____ **Client Number:** _____

Staff Name: _____ **Date:** _____

Info received from: (include relationship to client) _____

Please answer these questions to make sure your needs are identified. Your answers are important to help us serve you better. If you are filling this out for someone else, please answer **from their view**. Parents or guardians usually complete the survey on behalf of children under age 13.

SECTION I – Please estimate the number of days in the **last 2 weeks** (enter a number from 0-14 days): **0-14 days**

1. Over the last two weeks, how many days have you felt little interest or pleasure in doing things? ..... _____
2. How many days have you felt down, depressed or hopeless? ..... _____
3. Had trouble falling asleep or staying asleep or sleeping too much? ..... _____
4. Felt tired or had little energy? ..... _____
5. Had a poor appetite or ate too much? ..... _____
6. Felt bad about yourself or that you were a failure or had let yourself or your family down? ..... _____
7. Had trouble concentrating on things, such as reading the newspaper or watching TV? ..... _____
8. Moved or spoken so slowly that other people could have noticed? ..... _____
9. Been so fidgety or restless that you were moving around a lot more than usual? ..... _____
10. Remembered things that were extremely unpleasant? ..... _____
11. Were barely able to control your anger? ..... _____
12. Felt numb, detached, or disconnected? ..... _____
13. Felt distant or cut off from other people? ..... _____

SECTION II – Please check the answer to the following questions based **on your lifetime.**

14. I have lived where I often or very often felt like I didn't have enough to eat, had to wear dirty clothes, or was not safe ..... ☐ Yes ☐ No
15. I have lived with someone who was a problem drinker or alcoholic, or who used street drugs ..... ☐ Yes ☐ No
16. I have lived with someone who was seriously depressed or seriously mentally ill ..... ☐ Yes ☐ No
17. I have lived with someone who attempted suicide or completed suicide ..... ☐ Yes ☐ No
18. I have lived with someone who was sent to prison ..... ☐ Yes ☐ No
19. I, or a close family member, was placed in foster care ..... ☐ Yes ☐ No
20. I have lived with someone while they were physically mistreated or seriously threatened ..... ☐ Yes ☐ No
21. I have been physically mistreated or seriously threatened ..... ☐ Yes ☐ No
    a. If you answered **"Yes"**, did this involve your intimate partner (spouse, girlfriend, or boyfriend)? ..... ☐ Yes ☐ No

ALASKA SCREENING TOOL

SECTION III – Please answer the following questions based **on your lifetime.** (D/N = Don't Know)

22. I have had a blow to the head that was severe enough to make me lose consciousness ..... ☐ Yes ☐ No ☐ D/N
23. I have had a blow to the head that was severe enough to cause a concussion . ☐ Yes ☐ No ☐ D/N

If you answered "Yes" to 22 or 23, please answer a-c:

a. Did you receive treatment for the head injury? ..... ☐ Yes ☐ No
b. After the head injury, was there a permanent change in anything? ..... ☐ Yes ☐ No ☐ D/N
c. Did you receive treatment for anything that changed?..... ☐ Yes ☐ No

24. Did your mother ever consume alcohol? ..... ☐ Yes ☐ No ☐ D/N
    a. **If Yes**, did she continue to drink during her pregnancy with you? ..... ☐ Yes ☐ No ☐ D/N

SECTION IV – Please answer the following questions based on the **past 12 months.**

25. Have you had a major life change like death of a loved one, moving, or loss of a job? .... ☐ Yes ☐ No
26. Do you sometimes feel afraid, panicky, nervous or scared? ..... ☐ Yes ☐ No
27. Do you often find yourself in situations where your heart pounds and you feel anxious and want to get away? ..... ☐ Yes ☐ No
28. Have you tried to hurt yourself or commit suicide? ..... ☐ Yes ☐ No
29. Have you destroyed property or set a fire that caused damage?..... ☐ Yes ☐ No
30. Have you physically harmed or threatened to harm an animal or person on purpose? ... ☐ Yes ☐ No
31. Do you ever hear voices or see things that other people tell you they don't see or hear? ..... ☐ Yes ☐ No
32. Do you think people are out to get you and you have to watch your step?..... ☐ Yes ☐ No

SECTION V – Please answer the following questions based on the **past 12 months.**

33. Have you gotten into trouble at home, at school, or in the community, because of using alcohol, drugs, or inhalants? ..... ☐ Yes ☐ No
34. Have you missed school or work because of using alcohol, drugs, or inhalants? ..... ☐ Yes ☐ No
35. In the past year have you ever had 6 or more drinks at any one time? ..... ☐ Yes ☐ No
36. Does it make you angry if someone tells you that you drink or use drugs, or inhalants too much?..... ☐ Yes ☐ No
37. Do you think you might have a problem with alcohol, drug or inhalant use?..... ☐ Yes ☐ No

THANK YOU for providing this information! Your answers are important to help us serve you better.

CLIENT STATUS REVIEW

Case Number: _____

Type of CSR: ___Initial ___90-135 Day Follow-Up ___Discharge Administered by:_____

Date Completed: _____/_____/_____ Name: _____

Are you completing this survey for? (Please check one) ☐ I filled this out by myself (age 12 and older)
☐ I filled this out for a child/youth (Under age 12) ☐ Someone helped me fill this out

What best describes the reason you came in for services today? Select all that apply…
☐ I decided on my own ☐ I was encouraged by others (like family, friends, etc.)
☐ I was required to come (including court order, Office of Children's Services, etc.)

Health and Quality of Life	**# of Days**
1. How many days during the past 30 days was your physical health (including physical illness and/or injury) **not** good?	
2. How many days during the past 30 days was your mental health (including depression and/or problems with emotions, behavior, or thinking) **not** good? ----------	
3. How many days during the past 30 days did poor physical or mental health keep you from doing your usual activities, such as taking care of yourself, work, or recreation?----------	
4. How many days during the past 30 days have you had thoughts about suicide or hurting yourself? ----------	
	# of Times
5. In the past 30 days, how many times have you used emergency medical services such as the hospital, emergency room, or emergency medical technicians/health aides? ----------	
6. In the past 30 days, have you had an intimate partner slap, punch, shove, kick, choke, hurt, or threaten you? ☐ Yes ☐ No	

Substance Use	**# of Days**
7. How many days during the past 30 days have you had at least one alcoholic beverage? ----------	
8. How many days during the past 30 days have you had 4 or more alcoholic beverages? ----------	
9. How many days during the past 30 days have you used marijuana or illegal drugs (including medications not as prescribed or directed)? ----------	

Legal Involvement	
10. In the past 30 days, have you had any legal involvement (legal charges, court appearance, arrests, probation or parole) ☐ Yes ☐ No	
	# of Times
11. In the past 30 days, how many times have you been arrested? ----------	
12. In the past 12 months, how many times have you been arrested? ----------	

Health Behavior	**# of Days**
13. How many days during the past 30 days have you smoked cigarettes, pipes, or cigars AND/OR used chewing tobacco, snuff, or snus? ----------	
14. How many days during the past 30 days have you smoked 20 or more cigarettes per day? ----------	
15. How many days during the past 7 days did you participate in any physical activities or exercise such as running, sports (basketball, baseball etc.), swimming, bicycling or walking for exercise? ----------	
	# of Times
16. During the past 7 days, how many times did you drink 100% fruit juice or eat fruit? ----------	
17. During the past 7 days, how many times did you eat vegetables? ----------	

CLIENT STATUS REVIEW

Case Number: _____

18. Please answer each question by putting an **X** in the space that best describes how you feel about each item. Please use only one **X** for each question

How do you (<u>or your child</u>) feel about:	Terrible 	Unhappy 	Dissatisfied 	Mixed 	Satisfied 	Pleased 	Delighted 
Your housing?							
Your ability to support your basic needs of food, housing, etc.?							
Your safety in your home or where you sleep?							
Your safety outside your home?							
How much people in your life support you?							
Your friendships?							
Your family situation?							
Your sense of spirituality, relationship with a higher power, or meaningfulness of life?							
Your life in general?							

Please Answer Questions 19 – 21 if you have received services from this agency.

19. Please answer each question by putting an **X** in the space that best describes how you feel about each item. Please use only one **X** for each question.

How do you feel about the services you (<u>or your child</u>) received?	Terrible 	Unhappy 	Dissatisfied 	Mixed 	Satisfied 	Pleased 	Delighted 
I was treated with respect.							
I was given information about my rights.							
I helped to choose my treatment goals.							
I felt comfortable asking questions about my treatment.							
I was able to get all the services I needed.							
Because of the services I received:							
I am better able to handle daily life.							
I am getting along better with other people.							
I am better able to cope when things go wrong.							
The quality of my life has improved.							

20. What did you like about the services you received? _____

_____

21. What did you dislike about the services you received? _____

_____

Please Answer Questions 22 – 25 with the assistance of agency staff.

22. Which one of the following best describes your housing situation/living arrangement? (In the past 30 days, where have you been living most of the time?) (please check one)

- ☐ Adult in private residence – independent living (may live with others, but capable of self-care)
- ☐ Adult in private residence – dependent living (heavily dependent on others for daily living assistance)
- ☐ Child living in private residence (not in foster home)
- ☐ Foster home/foster care
- ☐ Homeless or shelter
- ☐ Jail or correctional facility
- ☐ Crisis residence (short term stabilization)
- ☐ Residential care facility (assisted living, halfway house, group homes, board & care)
- ☐ Residential treatment facility for:
  - ☐ Mental Health ☐ Substance Abuse ☐ Co-occurring Disorder
- ☐ Institutional care facility (care provided 24 hours, 7 days/week) (hospital, other inpatient psychiatric facility, nursing facility/home)
- ☐ Other (please describe) _____

23. Did you attend school at any time in the past three months? Yes ☐ No ☐

If you checked **'Yes,'** please indicate below the grade/educational **level you attended in the past three months**.

If you checked **'No,'** please indicate below the highest grade/educational **level you have completed**.

- ____ Grade Level (Write in Grade Level 1-12 or GED)
- ☐ No years of schooling
- ☐ Nursery School/Pre-School (Including Head Start)
- ☐ Kindergarten
- ☐ Self-Contained Special Education Class (No equivalent grade level)
- ☐ Vocational School
- ☐ College Undergraduate Freshman (1st year)
- ☐ College Undergraduate Sophomore (2nd year)
- ☐ College Undergraduate Junior (3rd year)
- ☐ College Undergraduate Senior (4th year)
- ☐ Graduate or Professional School (Master's, Doctoral, Medical, Law)

24. Which one of the following best describes your employment status during most of the previous **week**? (please check one)

- ☐ Employed full time working for money (30 or more hours per week); includes Supported Employment and Armed Forces
- ☐ Employed part time working for money (less than 30 hours per week); includes Supported Employment and Armed Forces
- ☐ Unemployed - actively looking for employment or laid off from job (and awaiting to be recalled) in the past 30 days
- ☐ Not in labor/work force (not employed and not actively looking for employment during the past 30 days); if you checked this box, please check one of the following:
  - ☐ Homemaker
  - ☐ Not Yet School Age
  - ☐ In Residential Care Facility
  - ☐ Retired
  - ☐ Student
  - ☐ In Residential Treatment Facility
  - ☐ Disabled
  - ☐ Job training program
  - ☐ Inpatient of Institutional Care Facility
  - ☐ Volunteer
  - ☐ Engaged in subsistence activities
  - ☐ Inmate of Jail or Correctional Facility
  - ☐ Sheltered/Non-competitive employment
  - ☐ Other (please describe) _____

25. Over the past 7 days, which one of the following best describes the number of hours you engaged in productive activities (e.g., school, employment, volunteering in community service, subsistence activities, etc.)? (Please check one of the boxes below)

☐ less than 10 hours ☐ 10-20 hours ☐ 21-30 hours ☐ 31-40 hours ☐ 41-50 hours ☐ More than 50 hours

CHUGACHMIUT
AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Phone #: _____

I am requesting information from:

Individual / Facility Name(s)	Phone Number and/or Fax Number

To be released to:

Individual / Facility Name(s)	Phone Number and/or Fax Number

PURPOSE OF USE/DISCLOSURE

The information will be used/disclosed for the following purpose:

- ☐ At the request of the patient; or
- ☐ Other (describe in detail): _____

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 individual(s)/facility(s) identified in this form.

TYPE OF INFORMATION

DATE RANGE OF RECORDS: _____ TO _____

I authorize the disclosure of the following PHI:

☐ History & Physical ☐ Discharge Summary ☐ Behavioral Health Assessment ☐ Diagnosis

☐ Operative Report ☐ Emergency Department Report ☐ Treatment Plan

☐ Diagnostic Reports (lab, x-ray, EKG, etc.) ☐ Progress Notes

☐ Other (specify): _____

Revised 7.18.24 KB

LENGTH OF AUTHORIZATION

Unless revoked, this authorization expires on: _____
If left blank, this authorization will expire 365 days from the date of the patient's signature.

APPLICABLE LAW

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

- My PHI is protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 & 164, and cannot be disclosed without my written consent except for certain purposes allowed by HIPAA as described in Chugachmiut's Notice of Privacy Practices.
- My PHI may include my social security number.
- If the person or entity receiving the PHI is not a health care provider or health plan covered by HIPAA, the PHI may redisclosed without protection by HIPAA, but may be covered by other laws protecting information on HIV/AIDS, mental health services, or genetic testing.
- 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.
- Chugachmiut may not condition treatment, payment, enrollment, or eligibility for benefits on whether or not I sign this authorization, except in certain limited circumstances provided for by HIPAA.

SIGNATURE

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent, Legal Guardian or Personal Representative Date

_____
Printed name of Parent, Legal Guardian or Personal Representative

_____
Description of Authority (if applicable)

**Note: Chugachmiut requires Legal Guardians and Personal Representatives to provide written verification of their authority to act on behalf of a patient.*

****

For Chugachmiut's Use Only:

Date Received: _____

Name/Title of Staff Member Processing Request: _____

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		

Revised 7/18/2024 KB

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)

****

For Chugachmiut's Use Only:

Date Received:_____

Name/Title of Staff Member Processing Request: _____