CONSENT FOR RELEASE OF INFORMATION

Check box for ROI type:☐Individual ☐Third party payer ☐Treating provider recipient ☐Non-treating provider entity

I, _____DOB_____, hereby give my consent for
(Name of Consumer) ***(mm,dd,yyyy)***

___Fairbanks Native Association Behavioral Health_ **to disclose to:**

Consumer initial

_____ _____

The following specific confidential behavioral health records:

Consumer initial each item

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

The purpose and need for the disclosure is to:

_____

This information may be transmitted via (consumer **initial each** approved means)

___fax ___verbal ___electronically ___hard copy

"NOTICE PROHIBITING RE-DISCLOSURE OF SUBSTANCE USE DISORDER INFORMATION"

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a consumer as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed 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 (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any consumer with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65." I also understand that I may revoke this consent through verbal communication or in writing at any time, except to the extent that action has been taken in reliance on it. Submit written revocation to FNA Behavioral Health Services, 3100 S Cushman St., Fairbanks, Alaska 99701. In any event, this consent expires automatically as follows: If not so revoked, this consent automatically expires on the conditions listed below: _____. ***[describe date, event, or condition upon which consent will expire, which must be no longer than reasonably necessary to serve the purpose of this consent]*** OR ***one year from the date of signing, whichever comes first***. I further acknowledge that the information to be released has been explained to me and certify that this consent is being given of my own free will.

_____	_____	_____
Signature of Consumer	*Date*	*Printed Name of Consumer*
_____	_____	_____
Signature of Parent/Guardian (If required)	*Date*	*Printed Name of Parent/Guardian*
	_____	_____
	Date	*Signature of Staff / Witness*