NSHC Authorization to Use and Disclose Health Information

Patient

Patient Name: _____ Patient Birth Date: _____

Ph. #: _____ Medical Record #_____

From

I authorize Norton Sound Health Corporation (NSHC) Behavioral Health Services to disclose Patient's health information as described below. Behavioral Health Services has up to five business days to prepare and release any clinical record documents.

To

Health information is to be disclosed to and received and used by:
(name/address of recipient)

Kawerak Inc. Vocational Rehabilitation Program
P.O. Box 948
Nome, AK 99762

Purpos

For the purpose(s) of:

☐ At my request

☑ Other purposes (specify each purpose): eligibility determination for vocational rehabilitation services

Information to be Disclosed

Description or nature of information to be disclosed and includes information in any medium, including paper, electronic, and verbal information: *(check all that apply)*

Specially Protected Information about:
(must be checked to be disclosed):

☐ **Mental health treatment**
☐ **Drug/alcohol abuse diagnosis, treatment, & referral**
☐ **HIV / AIDS Information**

☐ Records for the following dates or treatment: _____

☐ Other information (specify): _____

All health records from NSHC (Excludes the above Specially Protected Information unless box(es) checked.)

Notices

1. There is the potential for information disclosed under this authorization to be re-disclosed by the recipient and no longer protected by federal or state privacy laws. But, if the information being disclosed under this authorization includes HIV/AIDS, mental health, and drug/alcohol abuse information, then federal or state law may prevent the recipient from re-disclosing this information.

2. I may refuse to sign this authorization. My refusal will not adversely affect my ability to receive treatment, to enroll in a health plan, to be eligible for benefits, or to obtain payment for services unless this authorization is sought for purposes of research-related treatment, to determine my eligibility or enrollment in a plan, for underwriting or risk determinations, or if the services related to the information to be disclosed are performed solely for the purpose of providing that information to someone else.

3. I may revoke this authorization at any time by notifying, in writing, the Director of Behavioral Health Services of NSHC**;** however, any such revocation will not apply to any disclosure or action already undertaken based on this authorization.

4. I will receive a copy of this authorization after it is signed. I may inspect or request copies of information disclosed by this authorization.

Dates

Unless revoked, this authorization is valid for the following time period:

Beginning date: Ending (expiration) date:

Signature

SIGNATURE: I have read this authorization; I have had an opportunity to ask questions; I understand this authorization; and I am willingly signing this authorization.

_____ _____
Signature of Patient or legal/personal representative **Date**

If not signed by Patient, Authority to sign on behalf of Patient _____

_____ _____
Printed Name of BHS /Agency Witness (not required by departments of State of Alaska) **Date**

_____ _____
Signature of BHS /Agency Witness (not required by departments of State of Alaska) **Date**