KODIAK AREA NATIVE ASSOCIATION

HEALTH SERVICES

Authorization for Communication of Health Information

KANA may not disclose a patient's health information to anyone without patient consent or as authorized by law. If you would like to have anyone else, such as a friend or family member, involved with the coordination of your care, please complete this form. **All information must be completed fully and accurately, or document will not be valid.**

Patient Name (Last, First M.I. Suffix)			
Telephone Number:		DOB:	
Mailing Address:	City:	State:	Zip:

I authorize Kodiak Area Native Association to share and receive information with the following person(s):

Name (Last, First M.I. Suffix):	DOB:
Telephone Number:	Relationship to Patient:
Specific Information to be disclosed, please place an ☒ in all applicable boxes below:	
☐ Talk to my Doctor and medical staff	☐ Talk to Travel about my travel needs
☐ Talk to my Counselor and behavioral health staff	☐ Talk to Billing about my billing information
☐ Talk to my Dentist and dental staff	☐ Talk to Scheduling and make/cancel appointments
☐ Other:	
Please provide additional authorization for the specific release of any information related to the following	

☐ Drug/alcohol treatment*	☐ Sexually transmitted diseases	☐ Reproductive Health	☐Other

Name (Last, First M.I. Suffix):	DOB:
Telephone Number:	Relationship to Patient:
Specific Information to be disclosed, please place an ☒ in all applicable boxes below:	
☐ Talk to my Doctor and medical staff	☐ Talk to Travel about my travel needs
☐ Talk to my Counselor and behavioral health staff	☐ Talk to Billing about my billing information
☐ Talk to my Dentist and dental staff	☐ Talk to Scheduling and make/cancel appointments
☐ Other:	
Please provide additional authorization for the specific release of any information related to the following	

☐ Drug/alcohol treatment*	☐ Sexually transmitted diseases	☐ Reproductive Health	☐Other

Name (Last, First M.I. Suffix):	DOB:
Telephone Number:	Relationship to Patient:
Specific Information to be disclosed, please place an ☒ in all applicable boxes below:	
☐ Talk to my Doctor and medical staff	☐ Talk to Travel about my travel needs
☐ Talk to my Counselor and behavioral health staff	☐ Talk to Billing about my billing information
☐ Talk to my Dentist and dental staff	☐ Talk to Scheduling and make/cancel appointments
☐ Other:	
Please provide additional authorization for the specific release of any information related to the following	

☐ Drug/alcohol treatment*	☐ Sexually transmitted diseases	☐ Reproductive Health	☐Other

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HEALTH SERVICES

***Complete ONLY if you are requesting Drug/Alcohol information to be shared. Please place an ☒ in all applicable boxes below:**					
☐ All information related to drug/alcohol treatment	☐ Intake Assessment	☐ Treatment Plan	☐ Attendance Summary	☐ Medications	☐ Other

I understand that information disclosed by this authorization may be subject to re-disclosure and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule (HIPAA) [45 C.F.R. Parts 160 & 164], the Privacy Act of 1974 [5 U.S.C. 522a], or regulations on Confidentiality of Substance Use Disorder Patient Records [42 C.F.R. Part 2].

I understand my substance use disorder (SUD) records are protected under 42 C.F.R. Part 2 and HIPAA, and that they cannot be disclosed without my written consent except as provided for in those regulations. However, if my records are disclosed to another health care provider or other covered entity pursuant to this consent form, I understand that there is a potential for the recipient to use or redisclose those records subject only to HIPAA and not subject to the additional protections of 42 CFR Part 2, with the exception that my SUD records may not be disclosed in connection with civil, criminal, legislative, or administrative proceedings against me, unless with my specific consent or pursuant to a valid court order.

I understand that I may request a copy of this authorization. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment for my eligible benefits.

I understand that this authorization is valid 3 year from the signature date, or upon a minor turning 18 years old. I understand that I have the right to revoke this release of information at any time, except to the extent that KANA has already acted in reliance on it, and that such revocation must be done in writing.

_____

Date

_____ _____

Print Patient Name **Signature of Patient**

_____ _____

Print Parent/Guardian Name & Relationship **Signature of Parent/Guardian**

OFFICE USE ONLY

Medical Record Number (MRN): _____ Date Copied: _____ Staff Initials: _____