



Benteh Wellness Center

780 S. Snodgrass Drive · Palmer Alaska 99645 · Phone 907-671-6871 · Fax 907-746-0864



Authorization to Release Health Information (ROI)

All sections with *asterisks* are REQUIRED. Incomplete ROIs will not be processed.

Name of Participant whose information is to be released:

Participant Date of Birth:

Participant Social Security Number:

Name of Parent of Legal Guardian, if applicable (*required for minors*)

Participant Phone# and/or E-Mail (or legal representative, if applicable):

*I authorize Benteh Wellness Center to: * Release Information To and/or Obtain Information From

Organization/Person:

Address:

City/State/Zip Code:

Phone Number/Fax Number:

*Description of Specific Information to be Disclosed: (Please check all that apply) *

<input type="checkbox"/>	Complete Record (includes ALL items listed below)			
<input type="checkbox"/>	Assessments	<input type="checkbox"/>	Pharmacological Management Notes	<input type="checkbox"/>
<input type="checkbox"/>	Education Records	<input type="checkbox"/>	Medication Lists (if available)	<input type="checkbox"/>
<input type="checkbox"/>	Group Notes	<input type="checkbox"/>	Therapy Notes	<input type="checkbox"/>
<input type="checkbox"/>	Treatment Plans/Treatment Plan Reviews	<input type="checkbox"/>	Written and/or Verbal Communication	<input type="checkbox"/>
				Discharge Summaries
				Transfer Summaries
				Other:

From Intake Date to Discharge Date Or From Service Date : _____ To Service Date: _____

Specific Purpose of This Release of Information: (please check the best description):

Coordination of Care Personal Use Legal Use Emergency Contact Other: _____

I understand that authorizing the disclosure of the above information is voluntary and I understand that the information in my health record may include records relating to sexually transmitted diseases, drug and/or alcohol abuse treatment, psychiatric and mental health care, or other sensitive information. I understand that if I am seeking behavioral health services, that the entity seeking this authorization will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign the authorization. I also understand that if I am seeking Drug and Alcohol Services subject to 42 C.F.R Part 2, that the entity seeking this authorization is not permitted to condition treatment, payment, enrollment or eligibility for benefits on the provision of a 42 C.F.R Part 2 compliant release for treatment purposes. I understand that I may request a copy of this authorization. I understand that a photocopy/fax of this authorization is as valid as the original. I understand that there may be a fee for copying associated with this request. **I understand that I have the right to revoke this authorization at any time except to the extent that information has already been released. Authorizations for the release of alcohol and drug abuse records protected by 42 C.F.R. Part 2 can be revoked verbally. Authorizations covering all other health information must be revoked in writing.** I hereby authorize the use or disclosure of the health information as described above.

Prohibition On Redisclosure: I understand that information only covered by HIPAA (45 C.F.R. Parts 160 & 164) is subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Act. I understand that health information covered by federal law 42 C.F.R. Part 2 (Alcohol & drug abuse records prohibits any further disclosure of information that identifies a patient 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 C.F.R. 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 patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65. **42 C.F.R. Part 2 prohibits unauthorized disclosure of these records.**

Expiration Date or Event: _____ (Unless otherwise specified, this authorization will **expire one year from signature date**)

Signature of Participant *Required for Participants over 18 years old*

Signature Date

Signature of Parent/Legal Representative (if applicable) *Required for minors*

Signature Date

REVOCACTION SECTION: DO NOT complete this section when the authorization is initially signed. Only complete if the Participant wishes to revoke this authorization.
I hereby request that this authorization to release information be revoked, effective on the date of my signature below.

Signature of Participant/Parent/Legal Representative

Signature Date

If Participant revokes verbally, Employee will enter their name and job title followed by the date the Employee received the revocations instructions.

BWC Employee Use Only: Received on Date: _____ By Employee: _____ Revised 04/25/24