



MY House

300 N. Willow Street
Wasilla, Alaska 99654

Phone (907) 373- 4357 Fax (907) 373- 7887

CONSENT FOR DISCLOSURE OF INFORMATION

I, _____ DOB: _____, REQUEST/AUTHORIZE MY HOUSE

TO: _____ OBTAIN INFORMATION FROM:

NAME OF PRIMARY INSURANCE HOLDER: _____ DOB: _____

MAILING ADDRESS: _____

PHONE: _____ EMAIL: _____

I authorize the release and/or disclosure of the following information

- _____ RATES OF SERVICE
- _____ SERVICE PERIOD
- _____ INSURANCE ID AND GROUP NUMBERS
- _____ DOCUMENTATION OF AUTHORIZATION TO BILL OUT OF NETWORK
- _____ COB/EOB DOCUMENTS FROM PRIMARY INSURANCE HOLDER
- _____ DOCUMENTION OF PRIOR AUTHORIZATION
- _____ ALL DATES OF SERVICE THAT I AM COVERED THROUGH THE INSURANCE PROVIDER _____

FOR THE PURPOSE OF:

- _____ OBTAINING REQUIRED DOCUMENTATION FOR BILLING THIRD PARTY INSURANCE I AM COVERED UNDER
- _____ OBTAINING AUTHORIZATION TO BILL THE THIRD PARTY INSURANCE I AM COVERED UNDER

This ROI expires one year from the date is was signed, unless it is rescinded below.

INITIAL

I UNDERSTAND THAT THE INFORMATION IN THIS HEALTH RECORD MAY CONTAIN INFORMATION RELATING TO SUBSTANCE USE DIAGNOSIS AND/OR TREATMENT, MENTAL HEALTH DIAGNOSIS AND/OR TREATMENT AND/OR HUMAN IMMUNODEFICIENCY VIRUS (HIV) AND ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

I HAVE READ THE BACK OF THIS CONSENT AND HAVE BEEN PROVIDED WITH A COPY OF MY RIGHTS AND RESPONSIBILITIES AND UNDERSTAND THE PURPOSE OF THIS CONSENT

_____ SIGNATURE OF CLIENT	_____ PRINT NAME	_____ DATE
_____ SIGNATURE OF PARENT GUARDIAN/REPRESENTATIVE	_____ PRINT NAME	_____ DATE
_____ SIGNATURE OF WITNESS	_____ PRINT NAME	_____ DATE

STOP. ONLY SIGN BELOW IF YOU ARE WANTING TO RESCIND YOUR ORIGINAL AUTHORIZATION FOR RELEASE OF INFORMATION. IF YOU WISH TO CHANGE THE INFORMATION TO BE RELEASED YOU WILL NEED TO SIGN A NEW ROI.

SIGNATURE OF CLIENT

PRINT NAME

DATE

DISCLOSURE OF ALCOHOL AND DRUG TREATMENT INFORMATION

I UNDERSTAND THAT MY ALCOHOL AND/OR DRUG TREATMENT RECORDS ARE PROTECTED UNDER THE FEDERAL REGULATIONS GOVERNING CONFIDENTIALITY AND DRUG ABUSE PATIENT RECORDS, 42 C.F.R. PART 2, AND THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA"), 45 C.F.R. PTS 160 AND 164, AND CANNOT BE DISCLOSED WITHOUT MY WRITTEN CONSENT UNLESS OTHERWISE PROVIDED FOR BY THE REGULATIONS.

I UNDERSTAND THAT I MAY BE DENIED SERVICES IF I REFUSE TO CONSENT TO A DISCLOSURE FOR THE PURPOSES OF TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS, IF ALLOWED BY STATE LAW. I WILL NOT BE DENIED SERVICES IF I REFUSE TO CONSENT TO A DISCLOSURE FOR OTHER PURPOSES.

I HAVE HAD EXPLAINED TO ME AND FULLY UNDERSTAND THIS REQUEST/AUTHORIZATION TO RELEASE AND/OR OBTAIN RECORDS AND INFORMATION, INCLUDING THE NATURE OF THE RECORDS, THEIR CONTENTS, AND THE CONSEQUENCES AND IMPLICATIONS OF THEIR RELEASE. I UNDERSTAND THAT ONCE MY INFORMATION IS RELEASED, TNR CANNOT PREVENT THE REDISCLOSURE OF THAT INFORMATION, HOWEVER DOES PROVIDE A STATEMENT OF PROHIBITION AGAINST REDISCLOSURE OF PROTECTED HEALTH INFORMATION WITH DISCLOSURES MADE.

I UNDERSTAND THAT I MAY REVOKE A CONSENT IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION BASED ON THIS CONSENT HAS ALREADY BEEN TAKEN. SEE RECEPTION FOR INSTRUCTIONS TO REVOKE A CONSENT. IF TREATMENT IS MANDATED AS PART OF PROBATION REQUIREMENTS, A CONSENT MAY NOT BE REVOKED UNTIL CONDITIONS OF PROBATION ARE MET OR PROBATION ENDS.

I HAVE A RIGHT TO RECEIVE A COPY OF THIS SIGNED AUTHORIZATION. I ALSO UNDERSTAND THAT UPON MY WRITTEN REQUEST, TNR MUST PROVIDE A RECORD OF DISCLOSURES MADE FOR LEGAL, ADMINISTRATIVE OR QUALITY ASSURANCE PURPOSES.

NOTICE

PROHIBITING REDISCLOSURE OF ALCOHOL AND DRUG TREATMENT 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 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 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 PATIENT WITH A SUBSTANCE USE DISORDER, EXCEPT AS PROVIDED AT §§ 2.12(C)(5) AND 2.65.

SIGNATURE OF CLIENT

PRINT NAME

DATE