Your Non-Profit Community Health Center

Bethel Family Clinic
Box 1908
Bethel, AK 99559
907-543-3773 F-907-543-3545

RELEASE OF INFORMATION

I, ____, authorize the following agency:
(Client / Guardian Full Name)

Bethel Family Clinic
Behavioral Health
P.O. Box 1908
Bethel, Alaska 99559
Phone: 907-543-3773
Fax: 907-543-9859

☐ **To release the following behavioral health information to:**

☐ **To receive the following from:**

____
(Agency/Person's Name)
____
____
____

The following records: *Check*

___ **Assessment Summary** *Date:* _____
___ **Treatment Plan Summary** *Date:* _____
___ **Progress Notes Summary** *Date:* _____
___ **Psychological Report** *Date:* _____
___ **Psychiatric Report** *Date:* _____
___ **Substance Use Treatment Records** *Date:* _____
___ **Other** (specify): ________________________

The following *verbal* information: *Check*

____ **Ongoing verbal exchange of any information relevant to treatment.**
____ **Ongoing verbal exchange limited to progress and compliance.**
____ **Other verbal exchange:** ________________

Purpose of Authorization: ____

This authorization is effective:

☐ For six (6) months from the date of signature.
☐ Between the specified dates: _______________ to _______________.

- I understand that signing this release of information is voluntary and will not be a condition of BFC treatment, services, or other benefits.
- I understand I may revoke this release of information at any time by providing written notice to BFC and it will not affect my BFC treatment or other BFC services related to treatment, except that an authorization for records covered by 42 CFR Part 2 (Substance Use Treatment Information) may be revoked orally by notifying a staff member at BFC. I understand that any revocation will not apply to any disclosure or action already taken based on this release.
- I have been informed to whom any information will be given, its purpose, and who will receive the information. I will receive a copy of this release of information after it is signed.
- The information released in accordance to this authorization may be subject to re-disclosure and may no longer be protected by federal or state privacy laws. Information covered by 42 CFR Part 2 will not be disclosed without proper consent or unless permissible by law.

Signature of Client: ____ **Date:** __________________

Signature of Parent/Guardian: ________________________________ **Date:** __________________

Client Full Name: ____ **Client Date of Birth:** ______________
(First, MI, Last) *(MM/DD/YEAR)*

Client/Guardian Mailing Address: ___________________________________ *Phone:* ________________

Updated 03/26/2020