ALASKA TREATMENT CENTER

1577 C STREET SUITE 201 ANCHORAGE AK 99501
PHONE NUMBER: 907-222-2448
FAX: 907-268-6275

Records Release Authorization

PATIENT DEMOGRAPHICS

Full Name: _____ DOB: _____

I authorized Alaska Treatment Center to
Check both boxes for information exchange:

◯ Request information from ◯ Release information to

Name of person/facility: _____ Phone Number: _____

Address/city/state/code: _____ Fax Number: _____

I authorized the release of information relating to:

◯ Substance use disorder information ◯ Psychiatric Evaluation/Treatment

Specific information to be released: Dated from: _____ To: _____

Please check all the information to be released

◯ Diagnostic Records
◯ Medical screening & assessment
◯ Substance use screening, assessment evaluation
◯ Mental Health & Psychiatric Evaluations
◯ Medications
◯ Consultation & Treatment Plan
◯ Laboratory results
◯ Behavioral Health Setting, Assessment & Evaluation
◯ Others: Please specify
◯ Medical history/records
◯ Drug & Alcohol

Disclosure has been made for the purpose(s) listed below:

◯ Further treatment ◯ Legal ◯ Insurance ◯ Judicial/Court

How is the information going to be released:

◯ Verbal/oral ◯ Fax/mail

- *The patient acknowledges that he/she may withdraw this authorization at any time by submitting a written request to ATC. It is also understood that this withdrawal shall not impact nor affect information already disclosed prior to the request.*
- *The patient is aware that refusal to sign the authorization won't affect his/her treatment at ATC.*
- *The patient's copy of the authorization is deemed as original and will be subject to his/her review before request for disclosure.*
- *The patient does not grant permission for further release of information to any third party. He/she also understands that involuntary re-disclosure of his/her information will not make ATC liable.*
- *The patient is aware that his/her alcohol and drug treatment records are protected by 42 CFR, Part 2 and 45 CFR, Parts 160 & 164, and cannot be disclosed without their written consent unless permitted by regulations.*

My signature hereby authorizes Alaska Treatment Center to release/request information to the above

_____ _____ _____

Signature over Printed Name **Relation** **Date**