591 S. Knik Goose Bay Rd
Wasilla, AK 99654
Phone (907) 313 1333 Fax (907) 357-8781

CONSENT FOR DISCLOSURE OF INFORMATION

I,_____ DOB: _____, REQUEST/AUTHORIZE TRUE NORTH RECOVERY INC. TO: _____ DISCLOSE

INFORMATION TO AND/OR _____ OBTAIN INFORMATION FROM:

NAME OF ORGANIZATION AND/OR INDIVIDUAL_____

MAILING ADDRESS: _____

PHONE: _____ FAX PHONE: _____EMAIL:_____

I Authorize the release and/or disclosure of the following clinical treatment records:

INITIAL ALL THAT APPLY.

____ ALL LISTED BELOW OR

____ UA RESULTS
____ ASSESSMENT/INTERPRETIVE SUMMARY
____ TREATMENT PLAN/CASE REVIEWS
____ LEAVE MSG FOR CLIENT TO CONTACT AGENCT
____ FINANCIAL INFORMATION AND ATTENDENCE
____ ATTENDANCE
____ DISCHARGE SUMMARY
____ PROGRESS NOTES, TREATMENT/PLAN OR NOTES, OR CLOSING SUMMARY
____ OTHER _____

_____ ALL DATES OF SERVICES OR DATE or DATE RANGE of RECORDS TO BE RELEASED:_____

FOR THE PURPOSE OF: (INITIAL ALL THAT APPLY)

____ ALL LISTED BELOW OR

____ FURTHER TREATMENT/COORDINATION OF CARE
____ AT THE REQUEST OF THE CLIENT
____ LEGAL PURPOSES
____ FINANCIAL
____ PAYMENT HEALTH CARE OPERATIONS
____ OTHER_____

This ROI expires one year from the date is was signed, unless it is rescinded below.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 HELTH DIAGNOSIS AND/OR TREATMENT AND/OR HUMAN IMMUNODEFICIENCY VIRIUS (HIV) AND AQUIRED IMMUNE DEFICIENCT SYNDROME (AIDS)

I HAVE READ THE BACK OF THIS CONSENT AND HAVE BEEN PROVIDED WITH A COPY OF MY RIGHTS UNDER 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 RELEASE YOU WILL NEED TO SIGN A NEW ROI.

_____	_____	_____
SIGNATURE OF CLIENT	PRINT NAME	DATE

PLEAS SEE REVERSE SIDE FOR ADDITIONAL SIGNATURE

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