



AUTHORIZATION FOR RELEASE OF INFORMATION

CLIENT INFORMATION				
LAST NAME	FIRST NAME	MIDDLE NAME	DOB	PHONE#

I HEREBY REQUEST/AUTHORIZE RECORDS TO BE SENT:			
<input type="checkbox"/> TO	NAME OF PERSON/AGENCY	ADDRESS	CITY, STATE, ZIP CODE
<input type="checkbox"/> FROM			
Must check one			
<input type="checkbox"/> TO	NAME OF PERSON/AGENCY	ADDRESS	CITY, STATE, ZIP CODE
<input type="checkbox"/> FROM	AKEELA, INC	360 WEST BENSON BLVD	ANCHORAGE, AK 99503
Must check one			

TIMEFRAME FOR RECORDS: Specify the dates of service or time period for the records you want released.			
START DATE or TIME PERIOD/YEAR:		END DATE or TIME PERIOD/YEAR:	
TYPE OF RECORDS TO BE RELEASED: Select the specific types of information you authorize for release. INITIAL ALL that apply.			
INITIAL	Admission Assessment	INITIAL	Treatment or Discharge Summary
INITIAL	Attendance History	INITIAL	Client in Treatment Confirmation
INITIAL	Mental Health Only Assessment	INITIAL	Psychiatric Evaluation
INITIAL		INITIAL	Progress Notes
INITIAL		INITIAL	Lab/Drug Screening Results
INITIAL		INITIAL	Other (specify):
INITIAL		INITIAL	Treatment Plan/Updates
INITIAL		INITIAL	Leave a Message for Client/Correspondence

DELIVERY OF RECORDS: Please select how you would like your records to be delivered. Check ALL that apply		
*Email poses privacy risks, consider carefully before authorizing.		
<input type="checkbox"/> Fax (List Fax Number):	<input type="checkbox"/> Verbal	<input type="checkbox"/> Exchange Information Between Parties
<input type="checkbox"/> *Email (List Email Address):	<input type="checkbox"/> Mail Documents	<input type="checkbox"/> I Will Pick up Records

PURPOSE OF RELEASE: Check ALL that apply.		
<input type="checkbox"/> Coordination of Care	<input type="checkbox"/> Further Treatment	<input type="checkbox"/> My personal records
<input type="checkbox"/> Share with other health care providers	<input type="checkbox"/> Legal	<input type="checkbox"/> Other (specify):

AUTHORIZATION ACKNOWLEDGEMENT & CONSENT: Please read the statement below carefully. By signing at the end of this form, you are confirming that you understand and agree to the terms described. This authorization will expire at the time of discharge from services or 12 months from the date signed, whichever is sooner.

I understand that my health records may include sensitive information such as diagnoses or treatment related to behavioral health, mental health, substance use, alcohol or drug treatment, and information related to HIV/AIDS. I understand that disclosing this information may be necessary to support coordination of care between providers. I acknowledge that choosing not to share this information may affect the quality or continuity of my care. I voluntarily authorize the use and/or disclosure of my health information as described in this release. I understand that this authorization is not required as a condition for receiving treatment, payment, enrollment in a health plan (if applicable), or eligibility for benefits. I understand that if the person or organization authorized to receive this information is not a health care provider or health plan, the information disclosed may no longer be protected under federal privacy laws. However, I also understand that certain types of information, such as substance use treatment records, may still be protected under federal or state confidentiality laws and must continue to be kept confidential by the recipient. I acknowledge that my substance use treatment records are protected under federal law by 42 CFR Part 2 and under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164. These records may not be disclosed without my written consent, unless otherwise permitted or required by law.

RIGHT TO REVOKE: I understand that I have the right to revoke this authorization at any time. I understand that the revocation will not apply to any information that has already been disclosed or actions already taken in reliance on this authorization prior to the date the revocation is received. To revoke this authorization, I must submit my request in writing to Akeela by mail at 360 W. Benson Blvd. Suite 300, Attention: Privacy Officer, Anchorage, AK 99503, in person, or via secure portal message.

CLIENT SIGNATURE	DATE
CLIENT GUARDIAN/REPRESENTATIVE SIGNATURE (if applicable)	DATE

RECIPIENT INFORMATION - REDISCLOSURE NOTICE: This record which has been disclosed to you is protected by Federal confidentiality rules (42 CFR part 2). These rules prohibit you from using or disclosing this record, or testimony that describes the information contained in this record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against the patient, unless authorized by the consent of the patient, except as provided at 42 CFR 2.12(c)(5) or as authorized by a court in accordance with 42 CFR 2.64 or 2.65. In addition, the Federal rules prohibit you from making any other use or disclosure of this record unless at least one of the following applies: (i) Further use or disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or as otherwise permitted by 42 CFR part 2. (ii) You are a covered entity or business associate and have received the record for treatment, payment, or health care operations, or (iii) You have received the record from a covered entity or business associate as permitted by 45 CFR part 164, subparts A and E. A general authorization for the release of medical or other information is NOT sufficient to meet the required elements of written consent to further use or redisclose the record (see 42 CFR 2.31).