YUKON-KUSKOKWIM HEALTH CORPORATION

Authorization To Release Patient Psychotherapy Notes

Behavioral Health Services
P.O. Box 528 • Bethel, Alaska 99559
Phone: 907-543-6100 • Fax: 907-543-6159

Release to: _____ Organization: _____
(Name of person) or (Position Title)

Address: _____ City: _____ State: _____ Zip: _____

INFORMATION TO BE RELEASED FROM: (check all that may apply) ☐ YKHC Behavioral Health

☐ Phillips Ayagnirvik Treatment Ctr. ☐ McCann Treatment Ctr. ☐ KEYS Facility

☐ Other _____ ☐ Other: _____

Specific Purpose for this information: _____

TYPE OF INFORMATION TO BE RELEASED:

____ Psychotherapy Notes ..... From: ___/___/_____ To: ___/___/_____

As defined in 45 CRF Section 164.501, Psychotherapy Notes means notes recorded in any medium by a mental health professional documenting or analyzing the subject matter of conversation during a private individual, group, joint, or family counseling session. Psychotherapy Notes are separate from the rest of the individual's medical or mental health record.

____ Other (specify) _____ From: ___/___/_____ To: ___/___/_____

____ Other (specify) _____ From: ___/___/_____ To: ___/___/_____

I hereby ___authorize ___deny; the release of updated information listed above during the dates listed below or until the ascertainable event is met.

DURATION OF AUTHORIZATION (initial only one)

____ This Written Authorization shall expire upon completion of the request.

____ This Written Authorization shall remain valid only during the dates listed and shall expire immediately afterward. From: ___/___/____ To: ___/___/____

_____ This Written Authorization shall remain valid until an ascertainable event has been met.
Ascertainable Event*: _____

•This authorization may be revoked in writing at any time by notifying the Health Information Services Department (see address above). The revocation is valid except to the extent that the program, which is to make the disclosure, has already taken action.

• In the event a patient has been referred by the criminal justice system, the authorization is revocable upon the passage of an estimated amount of time or by the occurrence of a specified, ascertainable event, which can be no later than the final disposition of the conditional release or other action in connection with which authorization was given.

I am hereby authorizing YKHC to release the identified information above to the individual and/or organization listed above. I understand that I may refuse to sign this authorization. I am not required to sign this authorization in order to receive treatment, payment, enrollment or eligibility for benefits. I understand that a copy of this authorization must be provided to me upon completion of the request.

____/___ / _____ _____ _____ _____
Date *Print Patient Name* *Signature of Patient* *Signature Parent/Legal Representative*

Phone/Contact #: _____ (Additional information may be needed for proper identification.) _____
Relationship to patient

This authorization is valid only for the information identified above and to be released only for the purpose stated above and may not be used by the recipient for any other purpose. An expired, deficient, or falsified authorization of disclosure is prohibited under 42 CFR 2.31(d)

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 this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains 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. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. [52 FR 21809, June 9, 1987; 52 FR 41997, Nov. 2, 1987]

••• DO NOT COMPLETE BELOW THIS LINE. FOR OFFICE USE ONLY •••

PATIENT INFORMATION

Acct. #: _____

HR#: _____ DOB: ____ / ___ / ___

Name: _____
Last *First* *MI*

Residence: _____ Facility: _____

Date of Service: _____

FOR OFFICE USE ONLY

After hours release:

Person releasing information: _____

Date Released: _____