Bristol Bay Area Health Corporation

6000 Kanakanak Road, PO Box 130
Dillingham, AK 99576
907-842-9352 or toll free 800-478-5201 ext 6352
Fax: 907-842-9315

Authorization to Disclose Health Care Information

Patient Information

*Please **PRINT** all information*

Name: _____ Date of Birth: _____

Address: _____ Phone number: _____

Health Care Information

I, _____ , hereby authorize the **Bristol Bay Area Health Corporation** to disclose my health care information/records as described below to the person or organization listed below.

Name of Person or Organization: BBNA Head Start

Organization's Address: PO Box 310 Dillingham, AK 99576

Phone / Fax: Phone: 842-4059 Fax: 842-2338

For the purpose(s) of: Entrance to Head Start Program and referral tracking

Release the following health care information

(You must check at least one box in this section and supply the information or NO health care information can be released.)

My Health Care Information and Records concerning;

☐ The following treatment or condition:

_____
(Please describe)

☐ Treatment I received during the following dates:

From: _____

To: _____

☒ Other (including billing information):

Head Start Summary, Well child exams, dental exams, audio tests, follow up exams
(Please describe)

Please initial to authorize the information listed below to be used, disclosed, or received:

____ Mental Health ____ HIV/AIDS ____ Drug / alcohol / tobacco abuse diagnosis, prognosis, or treatment*

Information to be disclosed (describe how much, and what kind): _____

The above information will not be disclosed unless specifically authorized.

* The following notice accompanies a disclosure of health information concerning an individual in alcohol/drug abuse treatment made with the authorization or consent of such individual:

"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."

Termination of Authorization

(Check one box in this section and fill in blanks or nothing can be released.)
This authorization ends:

☐ In days from the date this was signed ☐ On the date of: _____ ☒ When the following occurs: *(Please describe.)* *July 31, 2014*

Acknowledgment: (*Please read and sign).*

I acknowledge and understand that I may revoke this authorization at any time by notifying the Bristol Bay Area Health Corporation (BBAHC) Privacy Officer on the designated form, except to the extent that action has been taken in reliance upon this authorization. BBAHC's Notice of Privacy Practices also describes how this authorization may be revoked. I may cancel this authorization at any time using any of the following:

1. Sign and date a "Revocation of Authorization" form, available form Bristol Bay Area Health Corporation.
2. Write, sign, and date a letter to Bristol Bay Area Health Corporation, Attn: Privacy Officer, PO Box 130, Dillingham, Alaska 99576 stating that I want to cancel this authorization.

I acknowledge and understand that if I do cancel or otherwise end this authorization, my act of canceling this authorization will not effect any actions or disclosures already taken based on my original authorization.

I acknowledge and understand that once Bristol Bay Area Health Corporation gives out my health care information as authorized by this document, Bristol Bay Area Health Corporation has no control over it. If the person or entity authorized to receive the above-described information is not a health care provider or health plan covered by federal or state privacy laws, then the information used, disclosed, and received under this authorization may be subject to re-disclosure and no longer be protected by those laws. Federal or state law, however, may restrict re-disclosure of mental health, drug/alcohol abuse, and HIV/AIDS information unless I specifically authorize re-disclosure.

I may refuse to sign this authorization. My refusal will not adversely affect my ability to receive treatment, payment for services, enrollment in a health plan, or eligibility for benefits, except if this authorization is sought for purposes of: research-related treatment; determining my eligibility or enrollment in a plan; underwriting or risk determinations; or providing health information to someone else and such services are solely for such purpose.

I received a copy of this authorization. I may inspect or request copies of information disclosed by this authorization.

I have been advised that my treatment, payment, enrollment, or eligibility for benefits is not and cannot be conditioned on my signing this authorization and I sign this authorization with the knowledge that I am not required to sign it in order to receive treatment.

_____ _____
Signature of **Patient** Date

_____
Patient Name Printed

*Requested by Legally Authorized Representative***

_____ _____
Signature of Legally Authorized Representative** **Printed Name** of Legally Authorized Representative**

_____ _____
Address of requesting party **if different than patient's** Phone Number of requesting party

***If this authorization is being signed by the Legally Authorized Representative of the Patient, the person signing this form must state the grounds for their authority to act on the Patient's behalf, as well as provide documentation to that effect.*

Grounds for authority: _____

For BBAHC Use Only:
Date Request Received: _____ Date Access Provided: _____
Name and Title of BBAHC member processing request: _____
Verification method: _____ Chart #: _____ Log #: _____