AUTHORIZATION TO FOR CITC/CSELC/ANJC TO OBTAIN PERSONAL INFORMATION

Name:	Birthdate:
Other Names Used:	

I authorize release of my information BY: ____

My information may be released TO:

☐ Cook Inlet Tribal Council ☐ Clare Swan Early Learning Center ☐ Alaska Native Justice Center

My **Contact Person** at CITC/CSELC/ANJC is: ____. If records include 42 CFR Part 2 records, this is to be the person who is authorized at the entity to receive the records.

Provide the information to CITC/CSELC/ANJC: *Check all that apply*

☐ **Verbally:** Participant information may be discussed between the individual/organizations named above

☐ **By Mail:** ____
Street Address or P.O. Box City State Zip

☐ ***By Fax:** ____

☐ ***By Email:**

** Using Fax/Email may increase certain privacy risks including risk of accidental disclosure & cyberattack.*

The following information is authorized to be disclosed/sent to the party stated above: *Describe the information or documents that are required for the benefit/program being applied for:*

I have been given sufficient time to read, understand, and ask questions about this form, and I understand the following:
HIPAA: I have a right to: (1) receive a copy of this signed authorization upon request; (2) refuse to sign this form/authorization; and (3) inspect or copy my information. I understand an entity may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on a decision to sign this form, unless it is necessary for the entity's proper treatment of me, obtaining payment for my services, or its healthcare operations. I may arrange to inspect or copy information by contacting CITC. **42 CFR Part 2:** Substance Use Disorder treatment information is protected under the federal regulations governing the confidentiality of SUD patient records and cannot be disclosed without my written consent unless otherwise provided for in the regulations. Recipients of my information pursuant to this authorization may not further disclose my substance use disorder information without my consent, unless specifically allowed under 42 CFR Part 2 or HIPAA. Recipients will be notified of this obligation in the Prohibition on Re-Disclosure which must accompany all disclosures of my substance use disorder information. **VAWA:** Information covered by Violence Against Women Act may be disclosed and I understand the type of information, reason for sharing, and potential recipients authorized in this release under this release.

Why are you requesting this disclosure?

☐ Care Coordination ☐ Legal ☐ School/Education ☐ Employment/Benefits ☐ Other:______________________

Expiration: This authorization expires **2 years** from the date signed *or* this requested date:______________/_______/_________

Revocation: I understand I may revoke authorization at any time by notifying the Person or Organization I am authorizing to release records. I may also notify my contact person at CITC of a revocation and they will withdraw the request for records. Revocation is not effective until received and is not effective for disclosures already made in reliance on the authorization.

I authorize disclosure of the requested records and understand they may contain sensitive information.

Signature:__________________________________ **Print Name:**__________________________ **Date:**____________

Address: ____
Street Address or P.O. Box City State Zip

Relationship to Participant: ☐ Self ☐ *Parent/Guardian ☐ *Legally Authorized Representative

** Attach proof of relationship to the Participant of parent/guardian or legally authorized representative.*

Minor's Signature, if 42 CFR Part 2 records about Minor:_________________________________**Date:**______________

YOU MUST SUBMIT A COPY OF A VALID PHOTO ID WITH THIS REQUEST