Cook Inlet Tribal Council: Recovery Services
Contact Form

Date: _______________

By placing my initials I understand that the intake process will take approximately 2 to 3 hours and I will be required to be present the entire time:___________Initial

Name:______________________________, ___________________________,________________________, ______________________________
First Middle Last Suffix Maiden Alias

Date of Birth:____/____/______ Social Security Number: ____________________________

Gender: Male Female Transgender

Gender Identity: Male Female Transgender Male Transgender Female Queer non-conforming Two Spirit Inter sex Cisgender

Do Not identify with any above No Response\Refuse Other ____

Sexual Orientation: Bi-sexual Gay Heterosexual Lesbian Pansexual Queer No response\refuse Unknown

Other **Preferred pronoun:** He\His She\Her They\Them Ze\Hir Prefer first name as pronoun______________________________________

Race:

❑ Alaska Native/American Indian ❑ Caucasian/White ❑ African American/Black ❑ Japanese
❑ Asian ❑ Chinese ❑ Filipino
❑ Korean ❑ Native Hawaiian ❑ Guamanian/Chamorro
❑ Samoan ❑ Other Asian ❑ Other Pacific Islander
❑Other Race: please describe____

Hispanic Ethnicity: ❑Not Hispanic ❑Mexican/Mexican American ❑Puerto Rican ❑ Cuban ❑ Another Hispanic,Latino Spanish

Alaska Native Ethnicity: ❑Aleut ❑ Alutiiq ❑Athabascan ❑ Eyak ❑ Haida ❑ Siberian Yup'ik Inupiat Tlingit Tsimshian

Regional Corporation: Check if you are a shareholder of one of the 13 Regional Native Corporations

❑ Ahtna, Inc ❑ The Aleut Corporation ❑ Arctic Slope Regional Corporation
❑ Bering Straits Native Corporation ❑ Bristol Bay Native Corporation ❑ Calista Corporation
❑ Chugach Alaska Corporation ❑ Cook Inlet Region, Inc ❑ Doyon, Ltd
❑ Koniag, Inc ❑ Nana Regional Corporation ❑ Sealaska Corporation
❑ The 13th Regional Corporation ❑ CIRI family member ❑ CIRI descendant
❑ None

Mailing Address: ___________________________ **City:** _____________________ **State:** ______________ **Zip Code:** ________________

Home/Cell Number: ___________________________________ **Email Address:** ____

Other Contact numbers:___________________________ Can we leave a message? ❑ Yes No **If *Yes*** is an ROI in place? ❑ Yes ❑ No

Referral Name: ___________________________ **Referral Agency:**_____________________ **Referral Phone Number:**_________________

Please answer the below Questions:

1. Have you ever tested positive for TB? ❑ Yes ❑ No If so when? ____
2. IV Drug User? ❑ Yes ❑ No
3. Who were your referred by: ❑ ASAP ❑ Probation ❑ OCS ❑ CITC ❑ Other (list) ________________________
4. Are you currently incarcerated? ❑ Yes ❑ No
5. Are you required to get an assessment for your referral agency? ❑ Yes ❑ No
6. When was the last day the applicant used substances? ________________

Medical Provider Facility Name: ____Contact Number: _____________________

Are you Pregnant: ❑ Yes ❑ No ❑ Don't Know **If yes,** who/where are you receiving Prenatal Care? __________________________________

Any Known Allergies: ____

FOR STAFF USE:

Admission Program: ❑ IS ❑IOP/OP ❑Recovery Journey (ETC) ❑Chanlyut ❑ Youth Assessment (CAIS) ❑ Youth OP (CAOP)

Participant ID: ___________________________

Five Factor ID: ___________________________

Revised 7.2021

Cook Inlet Tribal Council Recovery Services

BILLING INFORMATION

LAST NAME:________________________ FIRST NAME:________________________ MI:_________

MAILING ADDRESS: ________________________ CITY________________STATE_____ZIP:________

STREET ADDRESS (if different):________________________CITY________________STATE_____ZIP:________

HOME PHONE:________________ WORK PHONE:________________ CELL PHONE:________________

DOB:________________ SSN:________________ SEX: M ____ F ____ CHART#________________

EMPLOYER:________________________ OCCUPATION:________________________

EMERGENCY CONTACT PERSON:________________________ CONTACT'S PHONE:________________

COST, PAYMENT SOURCES, & ARRANGEMENTS

Treatment Services:

____Self Pay
____Guarantor (see below)
____Insurance:________________
____Medicaid, Recipient ID#:________________
____ Sliding Fee Scale (Rate $_______)
____Non-beneficiary

PAYMENT FORM: Cash _____________ Check _____________ Credit Card ___________ Receipt #______________(cash or check payment)

GUARANTOR AND INSURANCE INFORMATION (IF ANY)

GUARANTOR (PERSON/AGENCY):________________________

LAST NAME:________________________ FIRST NAME:________________________ MI:_________

MAILING ADDRESS: ________________________ CITY________________STATE_____ZIP:________

DOB:________________ SSN:________________ SEX: M ________ F ________

PHONE:________________ RELATIONSHIP TO PARTICPANT:________________

DETAILS & AMOUNT TO PAY:$________________________ WRITTEN CONFIRMATION: Y N

PRIMARY INSURANCE CARRIER:________________________

ADDRESS:________________________ CITY/STATE/ZIP:________________

INSURED'S ID#:________________________ GROUP#:________________

INSURED'S NAME:________________________ INSURED'S EMPLOYER:________________

INSURED'S GROUP NAME:________________________ RELATIONSHIP TO PARTICIPANT:________________

SECONDARY INSURANCE CARRIER:________________________

ADDRESS:________________________CITY/STATE/ZIP:________________

INSURED'S ID#:________________________ GROUP#:________________

INSURED'S NAME:________________________ INSURED'S EMPLOYER:________________

INSURED'S GROUP NAME:________________________ RELATIONSHIP TO PATIENT:________________

I hereby agree to pay CITC the fee for treatment services. Payment is due at the time the appointment is scheduled. Funds are non-refundable if I no show or cancel my appointment. Appointments are permitted to be rescheduled one time only. I am required to give 2 business days (48 hours) notice to reschedule my appointment. I understand that I am financially responsible for all costs, including those associated with closing my file. I understand that I am responsible for all costs not covered by my guarantor, insurance or Medicaid. I agree to make payments as outlined above, and understand that if I fail to make payments as such, my account will be turned over to Transworld Systems Inc for further collection action. It is my responsibility to notify Recovery Services of any change in mailing address or phone number. I hereby declare that I have read this form, or have had it read to me, and that I fully understand its meaning. I consent to the terms knowingly and voluntarily, and I am not under any undue duress, nor am I under the influence of any intoxicating alcohol or drugs.

________________________ ________________________
PARTICIPANT SIGNATURE **DATE**

________________________ ________________________
GUARANTOR SIGNATURE (IF APPLICABLE) **DATE**

________________________ ________________________
STAFF SIGNATURE **DATE**

Original Copy - Billing Office *Copy – Participant's Chart/Primary Counselor/ Participant's Copy*

FEE FOR SERVICES

Participant ID# ______________________________

Estimated Cost for Treatment services if billed at 100%

Beneficiaries

Comprehensive Substance Use Assessment		$ 100.00
Alaska Screening Tool (AST)		$ 35.00
	Total	$135.00
Services As Needed:		
Case Management		$18.75 per 15 minutes

I am signing this form acknowledging that I have been made aware of the cost for assessment services provided at Recovery Services. I understand the projected cost of services is only an estimate and that I will be charged only for provided services. I do understand that I am financially responsible for all costs. I will meet with the Billing Department to determine whether or not I qualify for the sliding fee scale.

______________________________ ______________

Participant Signature Date

______________________________ ______________

Signature and Title of Witness Date

Non beneficiaries

Comprehensive Substance Use Assessment		$ 300.00
Alaska Screening Tool (AST)		$ 35.00
	Total	$335.00
Services As Needed:		
Case Management		$18.75 per 15 minutes

I am signing this form acknowledging that I have been made aware of the cost for assessment services provided at Recovery Services. I understand the projected cost of services is only an estimate and that I will be charged only for provided services. I do understand that I am financially responsible for all costs. I will meet with the Billing Department to determine whether or not I qualify for the sliding fee scale.

______________________________ ______________

Participant Signature Date

______________________________ ______________

Signature and Title of Witness Date

CONSENT TO TREATMENT AND ACKNOWLEDGEMENT OF SERVICES

Participant Name:_________________________ Participant ID#: ___________________

My signature below indicates that I have read or had read to me in a clear and understandable manner the information indicated. I was able to ask questions and express concerns, which have been adequately responded to by a program staff person. I understand the purpose of the program as well as the potential benefits and risks that are involved. I understand my participation in this program is voluntary and that I may end my participation at any time should I feel it is in my best interest to do so. I understand that there are certain situations where the program is required to report to an external agency regarding my case without my written permission.

Handbooks, Orientation, and Intake Information:

- I am aware of and have reviewed all the information contained in the handbook(participant copy):
  - HIPAA Privacy Practices & Notice of Confidentiality of Alcohol/ Drug Abuse Information
  - Informed Consent and Agreement to Participate
  - Rights & Responsibilities including
    - Any restrictions CITC/RS might place on me.
    - Events, behaviors, and attitudes that may lead to restriction and/or lose of my privileges. How I may regain privileges that have been lost or restricted.
    - Counselor Code of Ethics
  - Participant Grievance Policy and Participant Acknowledgement Statement
  - Consent for Evaluation
    - The quality of care I receive.
    - Achieving and maintaining my goals and responding to follow-up contact (outcomes). My satisfaction with the services I receive.
    - Focus Groups that are held quarterly by independent evaluators.
  - Health and Safety Regulations regarding TB, HBV, HIV and STDs. I understand that I can have a referral though case management services or be provided with a list of medical providers who can offer testing
- I am aware of the program activities, expectations, procedures, and services including: assessment recommendations process sober support meetings, urine analysis testing, case staffing, and discharge requirements.
- I was introduced to my recovery services clinical team members. If any of the staff on my team were not available at this time, I am aware of names and phone numbers to contact if needed.
- I am aware of my fees and payment obligations.
- I am aware of the program hours of operations and access to after-hour services, if appropriate.
  - I have the telephone numbers to the unit and the unit address for CITC Recovery Services locations:
    - 3600 San Jeronimo Drive, Anchorage AK 99508 office hours are Monday-Friday 8am–6pm. 907-793-3200
    - 851 WestPoint Dr. Ste 310, Wasilla AK 99654 office hours are Monday-Friday 8am – 5pm 907-357-5400
- If I am experiencing a crisis situation after hours I can call the following numbers for assistance:

  Ernie Turner Center (907) 688-1750
  Crisis Line (907) 563-3200
  Suicide Prevention Lifeline 1 800-273-TALK (8255)
  Care line Crisis Intervention 1 877-266-4357 (Statewide)

- I am aware of the community resources and other services available to me.
- I was given a tour of the facility and emergency procedures
    - The participant is able to assist themselves in life threatening situation such as fire emergencies and natural disasters. If no, the staff and participant will develop a plan and include it in the participant's file.
      ________ YES ______NO

I hereby apply for admission as a voluntary participant in the Recovery services treatment programs that include: First Step Assessment Center and Intensive Case Management Services. I agree to conform to the rules and regulations of the program, which I have read and understand. I agree not to drink alcohol or use mind altering substances while I am a participant of the program, unless prescribed by a physician. I also hereby authorize payments directly to the program of any insurance benefits that would otherwise be payable to me for the treatment provided by the program.

Participant Signature:______________________________ Date: ______________________

Staff Signature:___________________________________ Date: ______________________

Participant's Acknowledgement/Agreement For Evaluation:

Evaluation - I grant permission to CITC Recovery Services Staff and Evaluation Team to provide information as outlined in the evaluation form and understand that I can withdraw this permission at any time in writing. I further understand that a withdrawal cannot cover information already given to the Evaluator. My signature below also acknowledges that I have received a copy of the Consent for Evaluation.

Participant Signature:______________________________ Date: ______________________

Staff Signature:___________________________________ Date: ______________________

CONSENT FOR TRANSPORTATION

I,_________________________________, hereby give my authorization for Recovery Services to transport me to and from appointments or recreational activities in program vehicles driven by insured employees of Cook Inlet Tribal Council, Inc.

____
Participant Print Name

_______________________________ __________________
Participant Signature Date

_______________________________ __________________
Witness Signature Date

Cook Inlet Tribal Council: Recovery Services
Intervention Services

CONSENT FOR USE AND DISCLOSURE OF PHOTOGRAPH/VOICE/VIDEO RECORDINGS

Please read this form carefully. If there is a word or anything you do not understand ask the staff member who is with you or your primary case manager to explain it. A new consent form must be signed for each activity.

Participant: ______________________ ______________________ ___
Last Name First Name MI

I, ________________________________, hereby voluntarily and without compensation authorize pictures/voice/video recordings to be made of me by (specify the name of the CITC RS Department, newspaper, magazine, television stations, brochure, etc.)
Intervention Services: First Step Assessment Center Cook Inlet Tribal Council

While I am participating in (describe the activity)
Early Intervention Program Services and Activities

I authorize disclosure of the photo/voice/video recording to (specify name and address of the organization, agency or individual(s) to whom the release is to be made)
Cook Inlet Tribal Council Recovery Services

I understand that the photo(s)/voice/video recording(s) for this activity is/are intended for the following purposes (describe purpose):
Supervision, evaluating clinical counseling techniques of the group leader and training

I understand that use of these photo(s)/voice/video recording(s) for this activity will be until the following date/condition (specify date, event or condition of expiration), or until I revoke this consent through writing at any time except to the extent that action has been taken in reliance on it. The strictest standards regarding confidentiality are maintained. Furthermore, this photo(s)/voice/video recording(s) will be kept in a secure area.
Initial: ________

I understand that I may review the photos or recordings or ask further questions on the use of these materials at any time by contacting (list contact name and phone number).
Initial: ________

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 and HIPAA, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent through writing or verbal dialogue at any time, except to the extent that such release has been taken prior to revoke date. To revoke in writing send letter to CITC Recovery Services, 3600 San Jeronimo Drive, Anchorage, AK 99508. To verbally revoke contact CITC Recovery Services (907) 793-3200. This consent expires automatically one year from the signature date or the date or event upon which is specified: __________________

____ ______________________
Participant Signature Date

____ ______________________
Witness Signature/Title Date

Cook Inlet Tribal Council: Recovery Services
Intervention Services

PERMISSION FOR FOLLOW-UPCONTACT

I_________________________________ , give Cook lnlet Tribal Council (CITC) permission to contact me during my
(Name: Please print clearly)
treatment episode and up to 14 months after I leave CITC Recovery Services to follow-up on my current status and services received. I understand that there will be multiple follow up points based on my program assignment(s) both throughout services and upon discharge. I agree to cooperate when staff members contact me. I understand that my participation is confidential and that Cook Inlet Tribal Council will follow its confidentiality policies and procedures in regards to my communication with its staff.

I understand that if I am unable to be contacted through information provided in this document, CITC staff will search Vine link to find my legal status. Organizations CITC may contact include: Anchorage Probation and Paro le, Palmer Probation Office, Ankle Monitoring Services LLC, Alaska Defendant Monitoring, Anchorage Correctional Complex East and West, Goose Creek Correctional, Spring Creek Correctional, Wildwood Correctional, and Lemon Creek Correctional.

I understand that any and all information in my records is protected under Federal law and regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations (in a covered life-threatening emergency, child abuse or neglect, threatened or actual crime at this program or against staff, or appropriate court order by a judge.) With this understanding, I authorize CTTC staff to use the information below for the specified purposes of locating me for follow- up. The recipient of this information may not disclose any of it without my further written consent except as provided for by Federal regulations 42 CFR Part 2.

I understand that the purpose of the contacts will be to provide support and encouragement for my status to continue to be alcohol and drug free as well as to obtain information regarding the program's impact and effective ness. I further understand I will be compensated for my participation. I can withdraw this permission at any time in writing by addressing my written revocation to: C!TC Recovery Services , 360 0 Sa n Jeronimo Dr. , Anchorage, AK 99508, or orally as provided below.

To verbally revoke, contact CITC Recovery Services at (907) 793-3200. I understand that this permission is in effect for fourteen (14) months from the date of my discharge from CITC Recovery Services.

I further acknowledge that the information to be released has been explained to me and certify that this consent is being given of my own free will.

The best way to reach me is:

Home Telephone: _______________________Best time to reach me at this number______________

Work Telephone:_________________________ Best time to reach me at this number______________

Mailing Address: ____

E-mail:____

Cook Inlet Tribal Council: Recovery Services
Intervention Services

Do you stay in different places in the summer vs. winter? Such as Fish Camps, Slope job, Fishing Boat, Cannery, etc..

Yes___ No___ If yes, identify where below.

Summer: Address/Phone# ____

Winter: Address/Phone#____

You also have permission to contact the following individual(s) to get information as to how I can be contacted or located

1.) Name: ____ Relationship: ______________________

Phone:____

2.) Name: ____ Relationship: ______________________

Phone:______________________________________

A kindly reminder: ***We will never post anything on your personal Facebook Page for your privacy. We will only message you for contact.***

Would you like to join our private CITC Survey FB page? (This will allow you see our reminders and updates on news feed and not on your personal page.) Yes___ N o___

May we contact you through a private messenger regarding your follow up through social media? Yes___ No___ If yes, please list your social media use names for us to contact you.

Name: ____

Are you homeless at this time? Yes___ No___

If yes, please list below of the places we may contact you at.

___ : Soup Kitchen; what day(s) of the week? M___ Tu___ W___ Th___ F___ Sat___ Sun___ ; Morning ___ Evening___

___ : Beans Cafe; what day(s) of the week? M___ Tu___ W___ Th___ F___ Sat___ Sun___ ; Morning___ Evening___

: Other restaurant names ____

What day(s) of the week? M___ Tu___ W___ Th___ F___ Sat___ Sun___ ; Morning___ Evening___

Do you stay at a shelter at this time? Yes___ No___

If yes, please list below of the places we may contact you at.

___Brother Frances Shelter

___Rescue Mission

___ AWAJ.C

___ Safe Harbor

___ The McKinnell House

___ The Covenant House

___ Catholic Social Services

___Congregate Shelter (Alex, Aviator)

___ Other: ____________________________

What day(s) of the week? M___ Tu___ W___ Th___ F___ Sat___ Sun___

Do you visit the library? Yes____ No____ If yes, name of branch?__________________________________

What day(s) of the week do you visit the library? M___ Tu___ W___ Th___ F___ Sat___ Sun___

Any other locations we may contact you at that have not been listed? Yes____ No____

If yes, please list below.

Address/Phone#____________________________________

What days of the week? M___ Tu___ W___ Th___ F___ Sat___ Sun___ ; Morning____ Evening ____

*Reminder: 3, 6, and 12 months after your Intake and Discharge, a Data Specialist may contact you for a follow up. The Data Specialist will not share any of your follow up information to anyone, such as assessors, counselors or case managers. The Information you give is only to help improve future needs with *CITC*. Once the follow up is complete, the Data Specialist will offer you a $10.00 gift card or $100.00 off your current bill with CITC-RS after each follow up.

Participant's Signature:____ Date:________________

Witness's Signature:____ Date:________________

Cook Inlet Tribal Council, Inc. / Alaska Native Justice Center / Clare Swan Early Learning Center / Get Out the Native Vote
3600 San Jeronimo Drive, Anchorage, AK 99508
Phone (907)-793-3600; Fax (907)-793-3423

Authorization to Obtain or Release (Exchange) Personal Information

Participant's Name: ______________________ DOB: ______________ (Month/Day/Year) Last four digits of SSN: __________

The signature below of ☐ Participant ☐ Parent ☐ Legal Guardian authorizes CITC and related entities[1] to obtain from or release to (exchange with) the following Facility, Organization, or Individual, the protected health and personal information of the participant named above:

Name: ____
(Facility, Organization, or Individual Name)

Address: ______________________________________ Phone: ______________

PURPOSE OF INFORMATION:
At the request of the participant for the purpose of treatment or services. Other specifications or special conditions, if any:

____

____

Psychotherapy Notes, as defined by HIPAA, CANNOT be released with this Authorization. See Psychotherapy Authorization to obtain those records. Nothing listed on this ROI is considered Psychotherapy Notes.

AMOUNT OR KIND OF WRITTEN (W), ELECTRONIC (E) AND/OR VERBAL (V) INFORMATION OBTAINED OR RELEASED (EXCHANGED): (circle and initial all that apply)

W / E / V ____Admission Summary
W / E / V ____Application for Services
W / E / V ____Attendance/Progress Report
W / E / V ____Billing Information
W / E / V ____Career Development Assessment
W / E / V ____Discharge Status
W / E / V ____Education Assessments
W / E / V ____FAS/FASD Assessments
W / E / V ____Health History/Physical Records
W / E / V ____Household Composition
W / E / V ____Housing
W / E / V ____Immunization Records
W / E / V ____Income and Wages
W / E / V ____Lab Reports (OCS and PO)
W / E / V ____Legal History
W / E / V ____Medication Records
W / E / V ____Medication Records – Substance Use
W / E / V ____Psychiatric Evaluation
W / E / V ____Psychological Evaluation
W / E / V ____Psychosocial History
W / E / V ____Service Plan (non-clinical)
W / E / V ____Supportive Services
W / E / V ____Treatment Plan (clinical)
W / E / V ____Treatment Recommendations for Level of Care (residential or outpatient)
W / E / V ____Other(specify)
____

***I give permission for the exchange of any and all information required for these purposes, including but not limited to grades, personal information, attendance, test scores, date and place of birth, schools attended, tribal affiliation, educational barriers, applicable community agencies, information covered by the Violence Against Women Act (VAWA) and other information through Q and/or Parent Connect and other resources between CITC (and related entities) and ASD, and within CITC and related entities. I understand if I am seeking VAWA services, I do not have to agree to share my information. CITC and related entities will still help me and provide services to the fullest extent legally permissible. This exchange is permissible until this release expires, even if I am no longer a student of ASD or participant of CITC. I understand that I may request a copy of the records being released at any time from the facility, organization or individual that released the records pursuant to this authorization**. ____(initial)

1. I understand: (1) I can refuse to authorize the release of any personal health information (PHI); (2) I am not required to release PHI in order to ensure health care treatment, payment, enrollment, or eligibility for health care benefits; (3) I may inspect or copy the information to be used or disclosed, as provided in 45 C.F.R. § 164.524; and (4) the information released may include information regarding psychiatric treatment (except psychotherapy notes), substance use treatment/rehabilitation, medical treatment, and HIV status. I give specific authorization for these records to be used and disclosed. If I have questions about disclosure of my CITC and related entities health information, I can contact the CITC Privacy Officer at 907-793-3403.
2. I understand: (1) I have a right to revoke this authorization at any time; (2) if I revoke this authorization I must do so in writing and present my written revocation to CITC for CITC and related entities PHI records, and in writing or orally for CITC and related entities substance use disorder treatment records; (3) the revocation will not apply to information that has already been released in response to this authorization; and (4) the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

   Unless otherwise revoked, this authorization will expire on the following date: . If this space is left blank, this authorization will be presumed to expire two (2) years after the signature date below.
3. I understand my substance use disorder treatment/rehabilitation records (if any) are protected under the Health Insurance Portability Accountability Act of 1996 (HIPAA) and its enacting regulations and, that depending on the nature of the record and treatment involved, my records may also be protected under the federal regulations governing confidentiality of substance use disorder patient records, 42 C.F.R. Part 2. I understand that only health information covered by 42 C.F.R. Part 2 (*i.e.,* alcohol and drug use or treatment) will continue to be protected by law from redisclosure once it leaves CITC. However, if the information is only covered by HIPAA, it is subject to redisclosure by the recipient and may no longer be protected. I understand my records cannot be disclosed by CITC or related entities and their programs that are subject to HIPAA without my written consent, beyond what is permitted under this authorization without my written consent, unless provided for by the regulations.
4. I understand that information covered by VAWA may be disclosed and understand the type of information, reason for sharing, and potential recipients.
5. ☐ ______ **(Initial) Check If information being disclosed is subject to 42 C.F.R. Part 2 (*i.e.,* alcohol and substance use or treatment).**
   NOTICE TO RECIPIENT: PROHIBITION ON REDISCLOSURE IF BOX IS CHECKED. This information has been disclosed to you from records that may be protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from further disclosing 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 such disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

By my signature below, I indicate that I have read this document or have had it read to me, I fully understand its meaning, and I consent to its terms knowingly and voluntarily.

______________________________ ______________
Signature **Date**

______________________________ ______________________ ______________
Signature of Guardian/Parent/Authorized Person **Relationship to Participant** **Date**

____
Printed Guardian Name

Signed copy received by participant: ☐ Ÿ^•____ ´ ☐ Þ[______, participant declined copy. **CITC Employee Initials:** ____________
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[1] Related entities include the Alaska Native Justice Center, Inc. (ANJC), Clare Swan Early Learning Center (CSELC), and Get Out the Native Vote (GOTNV).