Bethel Family Clinic
Box 1908
Bethel, AK 99559
907-543-3773 F-907-543-3545

Your Non-Profit Community Health Center

RELEASE OF INFORMATION

I, _____, authorize the following agency:
(Client / Guardian Full Name)

Bethel Family Clinic
Behavioral Health
P.O. Box 1908
Bethel, Alaska 99559
Phone: 907-543-3773
Fax: 907-543-9859

☐ **To release the following behavioral health information to:**

☐ **To receive the following from:**

_____
(Agency/Person's Name)
_____
_____
_____

The following records: *Check*

☐ **Assessment Summary** *Date:* _____
☐ **Treatment Plan Summary** *Date:* _____
☐ **Progress Notes Summary** *Date:* _____
☐ **Psychological Report** *Date:* _____
☐ **Psychiatric Report** *Date:* _____
☐ **Substance Use Treatment Records** *Date:* _____
☐ **Other** (specify): _____

The following *verbal* information: *Check*

☐ **Ongoing verbal exchange of any information relevant to treatment.**
☐ **Ongoing verbal exchange limited to progress and compliance.**
☐ **Other verbal exchange:** _____

Purpose of Authorization: _____

This authorization is effective:

- ☐ For six (6) months from the date of signature.
- ☐ Between the specified dates: _____ to _____.

- I understand that signing this release of information is voluntary and will not be a condition of BFC treatment, services, or other benefits.
- I understand I may revoke this release of information at any time by providing written notice to BFC and it will not affect my BFC treatment or other BFC services related to treatment, except that an authorization for records covered by 42 CFR Part 2 (Substance Use Treatment Information) may be revoked orally by notifying a staff member at BFC. I understand that any revocation will not apply to any disclosure or action already taken based on this release.
- I have been informed to whom any information will be given, its purpose, and who will receive the information. I will receive a copy of this release of information after it is signed.
- The information released in accordance to this authorization may be subject to re-disclosure and may no longer be protected by federal or state privacy laws. Information covered by 42 CFR Part 2 will not be disclosed without proper consent or unless permissible by law.

Signature of Client: _____ **Date:** _____

Signature of Parent/Guardian: _____ **Date:** _____

Client Full Name: _____ **Client Date of Birth:** _____
(First, MI, Last) *(MM/DD/YEAR)*

Client/Guardian Mailing Address: _____ *Phone:* _____