



Bethel Family Clinic
 P.O. Box 1908
 Bethel, Alaska 99559

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:

 (Agency/Person's Name)

To receive the following from:

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: _____

(First, MI, Last)

Client Date of Birth: _____

(MM/DD/YEAR)

Client/Guardian Mailing Address: _____

Phone: _____