

RELEASE OF INFORMATION (ROI)

Each section must be completed. Missing information will result in delays and the form may be invalid.

ROI TYPE	<input type="checkbox"/> Medical <input type="checkbox"/> Behavioral Health <input type="checkbox"/> Dental			PURPOSE OF ROI	<input type="checkbox"/> Further Treatment <input type="checkbox"/> Legal Proceedings <input type="checkbox"/> School <input type="checkbox"/> Insurance Claim <input type="checkbox"/> Other: _____			
PATIENT INFO	Patient Information: Name: _____ Birth Date: _____ Phone Number: _____ Address: _____ City: _____ State: _____ Zip: _____							
RELEASE INFORMATION	I hereby authorize Tanana Chiefs Conference to: (select all that apply) <input type="checkbox"/> Send/Disclose Records TO: Request Records FROM: <input type="checkbox"/> Exchange Information with: (back and forth communication)				Name of Person/Facility/Organization: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____ Email: _____			
EXPIRES	This form will expire (choose only one). <i>If no selection is made this authorization will expire one year from date of signature.</i> <input type="checkbox"/> On this date: ____/____/____ (MM/DD/YY) <input type="checkbox"/> Immediately after the information has been released							
CONSENT	Confirm your consent. <i>If no selection is made this information will not be disclosed.</i> <input type="checkbox"/> I do <input type="checkbox"/> I do not authorize the disclosure of information about HIV/AIDS <input type="checkbox"/> I do <input type="checkbox"/> I do not authorize the disclosure of information about behavioral health records <input type="checkbox"/> I do <input type="checkbox"/> I do not authorize the disclosure of information about substance use disorder				METHOD	<input type="checkbox"/> Verbal <input type="checkbox"/> Fax <input type="checkbox"/> Encrypted Email <input type="checkbox"/> Hard Copy		
REQUESTED RECORD DATES	Information to be used or disclosed: <input type="checkbox"/> All Dates of Services OR <input type="checkbox"/> Individual Dates Specified Below From ____/____/____ TO ____/____/____ (MM/DD/YY)		RECORDS REQUESTED	Check All that apply: <input type="checkbox"/> All Clinical Records OR <input type="checkbox"/> Immunization Records <input type="checkbox"/> OB/GYN <input type="checkbox"/> Consultation Notes <input type="checkbox"/> Operative Reports <input type="checkbox"/> Radiology Reports <input type="checkbox"/> History and Physical <input type="checkbox"/> Radiology Images <input type="checkbox"/> Health Summary <input type="checkbox"/> Lab Reports <input type="checkbox"/> Other: _____		SUB/BH DISCLOSURES	Substance Use Disorder or Behavioral Health (optional): <input type="checkbox"/> Diagnosis <input type="checkbox"/> Presence in Treatment <input type="checkbox"/> Treatment Plan <input type="checkbox"/> Assessment <input type="checkbox"/> Provider Letter <input type="checkbox"/> Medications <input type="checkbox"/> Other: _____	
PATIENT SIGNATURE	<ul style="list-style-type: none"> I understand that I may revoke any authorization to release my records in writing at any time by notifying TCC, except to the extent that TCC has already used or disclosed information in reliance on my authorization. Such a revocation will be effective when TCC receives notice. I understand that any substance use disorder treatment records are protected under the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and cannot be disclosed without my written consent unless otherwise provided for by those laws. For substance use disorder records: I understand that I might be denied services if I refuse to consent to a disclosure for purposes of TCC's treatment, payment, or health care operations, and that I will not be denied services if I refuse to consent to a disclosure for other purposes. For all other records: I understand that TCC may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization, unless that care is either research related or provided solely for the purpose of creating Protected Health Information for disclosure to a third party. I understand that 42 C.F.R. Part 2 prohibits the recipient of substance use disorder records from re-disclosing them to others, except with my consent, or in compliance with Part 2's rules. I understand that any other records disclosed based on this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a]. I may inspect or copy any information used or disclosed under this authorization. I have been offered a copy of this authorization, or may request one at any time. I understand that this authorization is voluntary and that I may refuse to sign this authorization. 							
	By signing, I certify that I have been given sufficient time to read this authorization, ask questions, and agree to disclosure.							
Signature of Patient (If the records requested are substance use disorder records, the patient's signature is required for disclosure, even if the patient is a minor) _____ Date _____								
Signature of Parent or Legal Guardian (where required or authorized to consent on behalf of the patient) _____ Date _____								
Print name of Parent or Legal Guardian (if applicable) _____ Relationship to Patient _____								