Assets, Inc.

CONSENT AND AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I hereby request that_____disclose the following health information for _____(client name). Date of birth: ___/___/____

The health information will include, as applicable, substance abuse and treatment information and/or mental health information. (kind and amount of information to be disclosed):

_____

_____

_____

The protected health information may be disclosed to:

Assets, Inc.
FASD Diagnostic Team Coordinator
2330 Nichols Street
Anchorage, AK 99508 Phone 907/279-6617 Fax 907/274-0636

_____

This protected health information is being used or disclosed for the following purpose (purpose of the disclosure):

FASD Diagnostic Team evaluation

_____

_____

I understand that Assets, Inc. may not condition the provisions of treatment on whether I provide consent and authorization for the requested use or disclosure.

This authorization shall be in force and effective until:

☐ Specify Expiration Date: **1 year from signature date on this document**

This date, event, or condition must ensure that the consent and authorization will last no longer than reasonably necessary to serve the purpose for which it is given.

I understand that, as set forth in Assets, Inc. Notice of Privacy and Confidentiality Practices, I have the right to revoke this consent and authorization, in writing, at any time by sending written notification to Assets, Inc., ATTN: Privacy Officer, at 2330 Nichols Street, Anchorage, AK 99508.

I understand that a revocation is not effective to the extent that Asset, Inc. has already relied on this consent and authorization for a use or disclosure of the health information. Acting in reliance includes the provision of treatment services in reliance on a valid consent and authorization to disclose information to a third party payor.

I understand that I have the right to refuse to sign this consent and authorization.

I have received a copy of this consent and authorization.

I understand that information used or disclosed pursuant to this consent and authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to inspect and/or request a copy my health information to be used or disclosed as permitted under federal or state law.

Name of Client_____

Signature of Client_____ **Date**_____

Printed Name of Parent or Legal Representative, if applicable _____

Signature of Parent or Legal Representative, if applicable _____ **Date**_____

Relationship to Individual _____

RECIPIENT INFORMATION: If the information released pertains to alcohol or drug abuse, the confidentiality of the information is protected by Federal Law (42 C.F.R. Part 2), prohibiting you from making any further disclosure of this information without the specific written consent and authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general consent and authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient/client.

FOR ASSETS, INC. USE ONLY:

The health information is being disclosed by (include the name or other specific identification of the person authorized to make the requested use or disclosure):

_____

_____

_____

Signature of staff person _____ **Date** _____

Print name and title: Anita Wilson, Privacy Officer