**Authorization For The Release Of Information Form:**

Offender Full Printed Name: DOB:

Social Security # *(Optional)*: DOC Offender #:

**I,**  i**n order to coordinate services between providers and**

 (Enter full name.)

**provide for better treatment for myself, hereby authorize the release of the below indicated information**:

*(Check boxes & initial.)*

[ ]  Admitting Information.

[ ]  Assessment / Intake Summary.

[ ]  Current Medications.

[ ]  Discharge Summaries.

[ ]  Diagnosis, Lab Results & Treatment For Medical Conditions Including HIV.

[ ]  DOC Supervision Status.

[ ]  Drug / Alcohol Testing Results.

[ ]  Legal Status.

[ ]  Medication History.

[ ]  My Diagnosis.

[ ]  Psychiatric & Psychological Evaluations And Testing Results.

[ ]  Psychological History.

[ ]  Treatment Documentation.

[ ]  Treatment Plans & Reviews.

[ ]  Release Plans.

[ ]  Other:

[ ]  Other:

[ ]  Other:

[ ]  Other:

[ ]  Other:

**To be exchanged between the Alaska Department of Corrections (DOC) and the agency / agencies indicated below**: *(Check boxes & initial.)*

[ ]  Adult Public Assistance.

[ ]  Adult Protective Services.

[ ]  Alaska Housing Finance Corp. (AHFC).

[ ]  ASAP.

[ ]  Division of Behavioral Health.

[ ]  Division of Child Support Services.

[ ]  Division of Vocational Rehabilitation.

[ ]  Federal Probation.

[ ]  Local Reentry Coalition:

[ ]  Office of Children’s Services.

[ ]  Office of Public Advocacy.

[ ]  Social Security Administration.

[ ]  Veteran’s Affairs.

[ ]  Enter agency name.

[ ]  Enter agency name.

[ ]  Enter agency name.

[ ]  Enter agency name.

[ ]  Enter agency name.

[ ]  Enter agency name.

[ ]  Enter agency name.

[ ]  Enter agency name.

[ ]  Enter agency name.

[ ]  Other:

[ ]  Other:

[ ]  Other:

[ ]  Other:

[ ]  Other:

**Each of the treatment providers, agencies and / or individuals indicated above are also authorized to exchange information with the individual or agency checked below:**

[ ]  The DOC Division of Probation & Parole.

[ ]  My defense attorney.

**A limited release is authorized to allow treatment providers to report to the Alaska DOC, the Superior Court, Municipal prosecutor and / or State prosecutor on my:**

[ ]  Treatment recommendations for purposes of bail conditions / sentencing / disposition.

[ ]  Ongoing compliance with court-ordered and / or probation / parole conditions.

**This Release of Information is valid until:**

*There has been a formal and effective termination or revocation of my probation, or parole, or other proceeding under which I was mandated into treatment.*

*If probation / parole supervision does not follow release from incarceration, this Release of Information will expire 365 days after release from incarceration.*

**The specific purpose of this release is to:**

*Assist with assessment; diagnosis, referral and coordination of treatment; legal management of criminal charges; and verification of compliance with court ordered conditions.*

**I understand that the information released may include medical and clinical information, including, but not limited to: psychiatric evaluations and treatment recommendations; substance abuse treatment / rehabilitation summaries; HIV status; and communicable disease results, which may pose a risk to the community such as Tuberculosis, Hepatitis, and reportable sexually transmitted diseases.**

**This information has been disclosed from records protected by federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. parts 160 & 164. The federal rules prohibit making any further disclosure of this information unless further 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 or 45 C.F.R part 160 and 164. I understand that I may revoke this consent, in writing, at any time except to the extent that action has already been taken in reliance on it.**

Offender Printed Name: Date:

Offender Signature:

Parent / Guardian / Authorized Representative Signature: (If applicable.) Date:

Employee / Witness Printed Name: Date:

Employee / Witness Signature: Job Title / Agency Affiliation:

**Distribution:** Original: Case File Copy: Offender

Copy: Person or Agency To Whom Information is Released.