North Star
Behavioral Health System

# NORTH STAR BEHAVIORAL HEALTH


North Star Hospital
2530 DeBarr Road
Anchorage, Alaska 99508
(907) 258-7575

Chris Kyle Patriots Hospital/Arctic Recovery
1650 S. Bragaw
Anchorage, Alaska 99508
(907) 272-6206

North Star RTC – Anchorage
1500 DeBarr Circle
Anchorage, Alaska 99508
(907) 865-7100

North Star RTC - Palmer
Mile 2.5 Clark-Wolverine
Palmer, Alaska 99645
(907) 746-7541


## AUTHORIZATION FOR RELEASE OF INFORMATION – Single Party

Patient's Name: _____ Today's Date: _____

Social Security Number: _____ Date of Expiration: _____

Date of Birth: _____ Contact Phone: _____

**I, _____, authorize North Star Behavioral Health (NSBH) to release to:**

**Name:** _____

**Address:** _____

**City/State/Zip:** _____

**the following information:**

- ☐ Discharge Summary
- ☐ Admission Summary
- ☐ Psychological Testing
- ☐ History & Physical
- ☐ Verbal Information
- ☐ Lab/X-ray
- ☐ Treatment Plan
- ☐ Other (please specify)

_____
_____
_____

**I authorize NSBHS to:**

☐ Send Info — Exchange Information (means that NSBH staff can communicate with the specific person, usually a therapist or doctor, and information can be shared between the two).

**This information is for the purpose of:** ***(Please check only one box)***
***(A separate Release Form must be filled out if more than one option is requested).***

○ Continued Treatment ○ Legal

○ Personal Use ○ Other (please specify): _____

**I understand that the information to be released includes information regarding the following:**

☐ Drug/alcohol abuse, treatment, rehabilitation ☐ Psychiatric Treatment

I understand that I may cancel this authorization, in writing, at any time. However, if NSBH receives a written cancellation after information has been sent out, our staff will contact you. Without written cancellation, this authorization will automatically expire as indicated in the "Date of Expiration" line at top of page. If no date is indicated in the "Date of Expiration" line, the request will terminate within 1 year from date of original request. NSBH does not determine treatment, payment, enrollment, or eligibility for benefits on whether an individual signs the authorization.

Signature of Patient: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____

Relationship if other than Patient: _____ Date: _____

Witness: _____ Date: _____

The above authorizations, initialed by me, are subject to cancellation or change at any time. If not previously cancelled, the authorizations will terminate as indicated in the box labeled EXPIRES above. I understand that a copy of this release may be sent to the party(ies) named above. I understand that I have a right to receive a copy of this release. The information being disclosed is confidential and protected by federal law. Federal regulation 42 CFR Part II governs the release of records pertaining to alcohol or other substance abuse or dependence treatment. This Release of Information facilitates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated thereunder." The Authorization for Release of Information must state that once the requested PHI is disclosed, the PHI's recipient may re-disclose, therefore the Privacy Regulations may no longer protect it.