	Providence Psych ER – Ph. (907)212-2800 Fax (907)212-2807
	Providence Medical Group Behavioral Health – 3760 Piper Street, Suite 1108 – Anchorage, AK 99508 Ph. (907)212-6900 Fax (907)561-8646
	Rainforest Treatment – 3250 Hospital Drive – Juneau, AK 99801 – Phone (907)796-8690
	Resolutions – Vivian F. Patton – 401 E Northern Lights Blvd, Suite 205 – Anchorage, AK 99503 – Ph. (907)770-7769
	Salvation Army Clitheroe Center – 3600 E 20th Avenue– Anchorage, AK 99508 – Ph. (907)243-1181, Detox (907)743-8716
	Sealaska Corporation – One Sealaska Plaza, Suite 400 – Juneau, AK 99801 - Ph. (907)586-1512
	Social Security Administration – 222 W 8th Avenue, Room A11 – Anchorage, AK 99513 – Ph. (907)274-4455
	State of Alaska Adult Protective Services –550 W. 8th Ave Anchorage, AK 99501 Phone (907)269-3666 Toll Free: (800)478-9996 Fax: (907)269-3688
	State Of Alaska Department Of Labor Unemployment Insurance – PO Box 107224 – Anchorage, AK 99510 – Ph. (907)269-4700
	State of Alaska Office of Children Services – 323 E 4th Ave Anchorage, AK 99501 Phone (907)269-4000 Fax: (907) 269-3901
	State of Alaska Public Advocacy - 900 W 5th Avenue – Anchorage, AK 99501 – Ph. (907)269-3500
	State of Alaska Public Assistance – 235 E 8th Avenue – Anchorage, AK 99501 – Ph. (907)269-6599
	Alcohol Safety Action Program/Coordinated Resources Project- Mental Health Court 303 K. Street Suite 250, Anchorage, AK 99501
	Adult Learning Center
	Division of Vocational Rehabilitation
	Nine Star - 125 W 5th Avenue, Anchorage AK 99501 Ph. (907)279-7827 Fax (907)644-9925

The following information may be released: ☐ written ☐ verbal ☐ electronically

PURPOSE OF RELEASED INFORMATION (check as applicable)	INFORMATION TO BE RELEASED/REQUESTED: (check as applicable)
_____Treatment planning	_____Presence in program
_____Personal use	_____Program status
_____Continued treatment	_____Admission and discharge dates
_____Legal use	_____Housing situation
_____Coordinate treatment	_____ASP stays in 12 months
_____Collaborating services	_____Homelessness verification
_____Obtaining housing options	_____Service utilization
_____Continuity of care	_____TB Status
_____Application for housing assistance	_____Current telephone number
_____Employment assistance	_____Current location
_____Conduct follow-up surveys	_____Current and previous assistance received
_____Income verification	_____Status on waiting list
_____Securing collateral information	_____Housing option available
_____Check eligibility	_____Interview schedule
_____Other (specify)	_____Name of case worker
	_____Client benefits
	_____Payee information
	_____Requirements for eligibility
	_____Mental health information
	_____Substance abuse treatment information
	_____AIDS-related information, diagnosis & test results
	_____Community service patrol pick-ups
	_____Develop budget plans
	_____Address financial responsibilities
	_____Physical examination
	_____Intake assessment
	_____Discharge summary
	_____Other (specify)

This authorization for release of information covers the period of healthcare from_____to_____.

1. I understand that my alcohol and/or drug treatment records are protected under Federal regulations governing confidentiality of Alcohol and Drug Abuse Patient records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by regulation.
2. I acknowledge that information to be released may include material that is protected by Federal and/or State law applicable to substance abuse, mental health and/or AIDS-related information. I SPECIFICALLY AUTHORIZE the release of confidential information to (please place or not to all applicable statements):
   _____Substance abuse (drug or alcohol) information from_____to_____.
   _____Mental health information from_____to_____.
   _____AIDS-related information from_____to_____.
3. I understand that authorizing the disclosure or release of this confidential information is voluntary. I can refuse to sign this authorization.
4. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
5. I understand that I may inspect or copy the information to be released or disclosed, as provided in 45 CFR 1674.524

6. I understand that may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state laws.
8. I understand that I have a right to revoke this authorization, in writing and present my written revocation to CHOICES, Inc. I also understand that if I revoke, the revocation will take effect on the day it is received by CHOICS, Inc., in writing, I understand that the revocation will not apply to my information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides by insurer with the right to contest a claim under my policy.
9. Unless otherwise revoked, this authorization will expire_____ days after I am discharged from CHOICES, Inc.

To the Recipient of Confidential Information: This information has been disclosed to you from records whose confidentiality is protected by Federal Regulation (42 CFR Part 2) prohibiting you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. The Federal regulations restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient.

Client Signature (Optional for Minors/Adults with Guardians)	Date
Personal Representative/Translator Signature	Date
Personal Representative/Translator Printed Name	Relationship to Client
Witness Signature	Date
Witness Printed Name	

A signed copy must be given to client: (client/parent/guardian to initial appropriate line)

_____I received a copy of this Authorization to Release Confidential Information

_____I declined a copy of this Authorization to Release Confidential Information

ACTION TO BE TAKEN:	FOR OFFICE USE ONLY:
Send for records	Date action taken:_____
Release CHOICES records	Action taken by: _____

HOW CHOICES PROTECTS YOUR PRIVACY
THE BASICS OF HIPAA

What is HIPAA?
As part of CHOICES commitment to provide the individuals and families we are privileged to serve with high quality, ethical care, we will always keep your health information confidential. We will share your information with parties not involved in your wellness planning, only when given specific permission to do so by yourself or your legal guardian, or in instances when we are legally obligated to do so.

Not only is this commitment part of CHOICES ethical code, it is also part of a federal law that came into effect on April 14, 2003, making it illegal to violate this part of our code. The Privacy Rule ensures that personal medical information you share with the people you work with at CHOICES and others who provide and pay for your healthcare is protected.

This law, the Health Insurance Portability and Accountability Act of 1996, or "HIPAA" for short, gives you the right to gain access to your records, request amendments to your health information, and limits the ways the providers may use your information. You have always enjoyed some of these protections under Alaska state law, but with HIPPA they are federally mandated and enforced with harsh consequences for violators.

HIPAA includes punishments for anyone violating the privacy of your protected health information. People or organizations who compromise your confidentiality and trust intentionally can be fined as much as $250,000 or go to jail for up to 10 years. Even accidentally breaking the rules can result in fines.

What brought about this law?
HIPAA is a broad law that covers a variety of issues. One goal was to enable people to easily move from one health insurance plan to another as they change jobs or become unemployed and allow providers treating you to share information more easily.

The law requires health care providers and payers to use standard formats for common transactions such as submitting an insurance claim on a patient's behalf. Today, with e-mail and access to the Internet, it is much easier for providers to share records, but it is also much easier for people to misuse the information they contain.

That's why the law includes sections with requirements for protecting your privacy and confidentiality and ensuring the security of your health information. Under the HIPAA privacy and security rules it is illegal under most circumstances to fail to adequately protect protected health information from unauthorized release or to release protected health information without permission to so from yourself or you legal guardian.

Who is covered by the HIPAA Privacy Rule?
Under Section 1172(a) of the Social Security Act, these regulations apply to health plans, a health care clearinghouses, and health care providers who transmit any health information in electronic form in connection with a health care transaction. HIPAA also indirectly affects business associates who have access to protected health information.

What is considered Protected Patient Information?
Protected health information (PHI) includes all identifying information you provide and information about your treatment, including the following: name; address; age; telephone number; fax number; social security number; diagnosis; medical history; medications; billing information; and physician's personal notes maintained by a covered entity, regardless of form, written, oral or electronic.

HIPAA's Privacy Rule is all about the use and disclosure of PHI. Obviously, providers use this information to assist them in determining the options available to best enhance your wellness. These providers may include doctors, psychiatrists, psychologists, clinicians, case managers, nurses, therapists, dietitians, and all members of your treatment team. Coders and billing department employees use confidential information to bill patients, their insurance companies, Medicare, Medicaid, or Denali Kid Care for services. Staff performing quality improvement activities may review confidential information to make sure you are receiving high quality care.

What is Minimum Necessary?
HIPAA requires health care employees to use or share only the "minimum necessary" information they need to do their jobs effectively. Covered entities must develop policies and practices to make sure the least amount of health information is shared. Everyone employee who accesses PHI must be identified, along with the types of PHI needed and the conditions for access.

The minimum necessary requirement does not apply to treatment. Clinical staff, members of your treatment team, can look at your entire record and freely share information with other members of the team caring for you.

This Notice of Privacy Practices describes how we use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law (see in the body of the Notice). It also describes your rights to access and control your protected health information.
We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. Whenever there is a material change to the uses and disclosures of protected health information, we will promptly revise and distribute our Notice or the revised Notice will be available for you at your next visit to the agency.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice please contact our Compliance Officer at (907) 333- 4343 or by mail at Anchorage CHOICES, Inc. 1231 Gambell Street, Suite 300, Anchorage, AK 99501. You may also contact the DHHS Office of Civil Rights at 200 Independence Avenue S. W., Washington D. C. 20201.

I. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

When you begin work with CHOICES, Inc. there are many forms that you will need to complete and data that you will provide. We are required to compile much of this information by the people that provide our funding. Your protected health information may be used and disclosed by our agency, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing services to you.

Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of CHOICES, Inc.

Following are examples of the types of uses and disclosures of your protected health care information that we will make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

A. Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care. We will also share information that you provide with supervisors or our internal team members so that they can assist in determining the best course of care and services for you.

B. Payment: Your protected health information will be used, as needed, to obtain payment for the services that we provide. This may include certain activities that your health insurance plan or service funder may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan/funder to obtain approval for the hospital admission. We may also disclose your information to another provider involved in your care as part of ensuring your eligibility for services.

C. Healthcare Operations: We may use or disclose, as-needed, your protected health information for our own health care operations in order to provide quality care to all consumers, to assess staff training needs or to ensure the efficiency of program operations. Health care operations include such activities as:

- Quality assessment and improvement activities,
- Employee review activities,
- Training programs including those in which students, trainees, or practitioners in health care learn under supervision,
- Accreditation, certification, licensing, or credentialing activities,
- Review and auditing, including compliance reviews, record reviews, legal services and maintaining compliance programs, or
- Business management and general administrative activities.

In certain situations, we may also disclose patient information to another provider or health plan for their health care operations.

D. Other Uses and Disclosures: As part of treatment, payment and health care operations, we may also use or disclose your protected health information for the following purposes:

- To remind you of an appointment,
- To inform you of potential treatment alternatives or options,
- To inform you of health-related benefits or services that may be of interest to you.

II. Uses and Disclosures that Require You be Given the Opportunity to Agree or Object

- **Others Involved in Your Healthcare:** We may use or disclose protected health information to your guardian or personal representative or any other person that is directly responsible for your care. If you are unable to agree or object, we may disclose such information as necessary if, based on professional judgment; it would be in your best interest. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

- **Communication Barriers:** We may use and disclose your protected health information if we attempt to obtain an authorization from you but are unable to do so due to substantial communication barriers that we cannot overcome and we determine, using professional judgment, that you intend to provide authorization to share information.

III. Other Required Uses and Disclosures

We may use or disclose your protected health information in the following situations without your authorization. These situations include:

A. In Connection With Judicial and Administrative Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceedings in response to an order of a court or magistrate as expressly authorized by such order or in response to a signed authorization.

B. To A Designated Hospital to Which a Client Is Involuntarily Committed: We may disclose protected health information to assure continuity of care.

C. To Report Abuse, Neglect, or Domestic Violence: We may notify government authorities if we believe that a patient is the victim of abuse, neglect, or domestic violence. We will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

D. Health Oversight Activities: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits; civil, administrative, or criminal investigations, proceedings or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law. We will not disclose your health information if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.

E. In a Medical or Psychological Emergency: We may disclose protected health information to direct medical service or mental health personnel if a medical or psychological emergency arises.

F. For Research Purposes: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

G. When Legally Required: We will disclose your protected health information when we are required to do so by any Federal, State, or local law.

H. Imminent Threat to Health or Safety: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

I. To Division of Mental Health and Developmental Disabilities in accordance with 7 ACC 71.400 - 7 ACC 71.449. We will disclose protected health information to DMHDD for health oversight activities and data collection as specified in Alaska law.

J. For all other disclosures of your PHI we must obtain a written authorization for release of information from you.

IV. Your Rights Regarding Protected Health Information (PHI)

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

A. Right to Inspect and Copy: You have the right to inspect and receive a copy of your protected health information. We may have to charge you for copying. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set. A "designated record set" contains PHI and billing records and any other records that we use for making decisions about you. If we perceive that providing you access to your record constitutes a danger to self or a danger to others, we can use our professional judgment regarding access.

B. Right to Request Restrictions: You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your case record not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

We are not required to agree to a restriction that you may request. If we believe it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If we agree to the requested restriction, we may not use or disclose your protected health information in violation of

that restriction unless it is needed to provide emergency treatment.

C. Right to Request Confidential Communications: You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You must make this request in writing. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. We are not required to honor your request, but if we do not do so, we will explain in writing.

D. Right to Amend: You may have the right to amend your case record. This means you may request an amendment of the information in your record for as long as we maintain this information. This request must be in writing and provide a reason for the amendment. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, we will do so in writing. You have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact your provider if you request an amendment.

E. Right to an Accounting of Disclosures: You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment, or healthcare operations as described in this Notice of Privacy Practices. By law it excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter time frame.

F. Right to a Paper Copy of This Notice: You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

V. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint in writing, with us by notifying our Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Compliance Officer at (907) 333-4343 or by mail at CHOICES. Inc., 1231 Gambell Street, Suite 300, Anchorage, AK 99501 for further information about the complaint process.

VI. Changes to This Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for PHI information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our office. The notice will contain on the first page, in the top right-hand corner, the effective date.

You will be offered a copy of the current notice when you visit our officers for services.

VII. Effective Date:

This Notice of Privacy Practices is effective February 12, 2009. Revised 2/ 17/ 2016

I have reviewed this Notice of Privacy Practices with a CHOICES, Inc. staff member and fully understand CHOICES, Inc. policies and my rights regarding the use of my protected health information.

_____ _____

Client Signature Date

_____ _____

CHOICES, Inc. Staff Signature Date

CHOICES, Inc.

1231 Gambell Street, Suite 300 • Anchorage, Alaska 99501

RIGHTS AND RESPONSIBILITIES

As an individual receiving services from any of the programs of CHOICES, you have the following rights and responsibilities;

1. Have your treatment records, communications, and personal information remain confidential under federal and state laws.
2. Not be denied services at CHOICES, Inc. Recovery Coordination on the basis of ethnicity, race, creed, religious preference, political affiliation, gender, age, sexual orientation, disability, HIV status, or in any manner prohibited by the laws of the United States or the applicable state.
3. Have your treatment plan that results in positive outcomes to the maximum extent possible.
4. Have humane care and protection from harm, abuse and neglect, and to treatment in the least restrictive, most appropriate setting.
5. Be free from misappropriation of your money or personal property by CHOICES, Inc. Recovery Coordination personnel.
6. Participate in all Recovery Coordination and follow through with your treatment plan.
7. Be informed of steps and activities Iinvolved in receiving Recovery Coordination services and treatment plan or modify your treatment plan that may affect your well-being.
8. Be informed prior to or at the time of admission and during treatment CHOICES, Inc. Recovery Coordination of all bills and charges for treatment, and other services.
9. To self-direct activities and participate in decisions regarding to Intensive Case Management.
10. An environment in which personal dignity, self-esteem and culturally atmosphere are promoted and personal liberty supported.
11. An individualized written treatment plan developed promptly, treatment plan based on the problems and goals to be worked on with 90-135 day review and reassessment of needs, and appropriate revisions of the treatment plan.
12. Be assigned a Recovery Coordinator if applicable.
13. Know approximately how long you will be in a recipient of CHOICES, Inc. Recovery Coordination services.
14. Take part in planning for discharge and be free of arbitrary transfer or discharge unless an event has occurred that is grounds for administrative discharge.
15. Be referred promptly for medical treatment when ill.
16. Not be secluded or restrained and be free of physical punishment.
17. Inspect and receive a copy of your case records, at a reasonable charge for photocopying, within policy limits conforming to Federal Code of Regulations 42 CFR Part 2 and state rules.
18. You may request a review of your records by notifying your Recovery Coordinator and Directing Clinician.
19. Not be photographed or otherwise identified in any media without your specific written consent.
20. Not participate in any research, or have information provided to any research agencies, without your specific written consent.
21. Not be observed behind two-way mirror or with videotape equipment without your written acknowledgment.
22. Voice complaints and file grievances without discrimination or reprisal.
23. Review, determination, and correction of any alleged violation of rights through discussions with the Recovery Coordinator and, if necessary, the Directing Clinician, following CHOICES, Inc. Dispute resolution procedure.
24. Confidentiality of HIV/AIDS status.
25. The right to nondiscriminatory access to services as specified in the American's with Disability Act of 1990.

PROGRAM RULES

Clients are expected to behave in a courteous, respectful manner at all times.
As a client at CHOICES, Inc. Recovery Coordination you may NOT:

1. Be verbally abusive or use profanity.
2. Act in a threatening manner toward CHOICES, Inc. Recovery Coordination staff or clients.
3. Become violent or disruptive of CHOICES, Inc. Operations.
4. Possess or sell illicit drugs on CHOICES, Inc. Property.
5. Possess weapons on CHOICES, Inc. Property.
6. Divert your medication by giving or selling your medication to others.
7. Continue involvement with illicit, or mind altering substances.
8. Use drugs that are synergistic with your medication or that may cause risk of death.
9. Fail to comply with treatment plan goals that affect or could result in serious health problems.
10. Fail to wear shirts and shoes at CHOICES, Inc. Loiter in CHOICES, Inc. Parking lot.
11. You are responsible for providing accurate information about your current issues and past illnesses.
12. You are responsible for following your treatment or service plan. If you do not understand your plan or want to make changes, you need to speak to your Recovery Coordinator or therapist.
13. You are responsible for reporting unexpected changes in your condition to your provider.
14. You are responsible for your actions if you do not follow your provider's instructions or refuse treatment.
15. You are responsible for keeping any appointments and when unable to do so, notify your provider 24 hours in advance.
16. You must assure that financial obligations for your health care are fulfilled and that any changes in your insurance are reported immediately if appropriate.
17. You must follow these guidelines or the agency reserves the right to refuse services.
18. You must inform your Recovery Coordinator if you are taking any other prescription medications.
19. Attendance at counseling sessions, whether individual or group, is mandatory.
20. Public use of personal medication at CHOICES, Inc. Is prohibited. This Includes both prescribed medications and over-the-counter medications, herbal natural medications, and vitamins. Clients are not to be exchanging personal medications, offering other clients personal medications, or displaying personal medications in public. Clients observed sharing or displaying will be directed to their Directing Clinician.
21. No Smoking at Center or 50 ft. from building.

Children are welcome In CHOICES, Inc. Recovery Coordination as long as they are properly supervised to protect the children and to prevent disruption of counseling sessions and other CHOICES, Inc. Activity.

You are welcome to pursue job search activities, at the WEB, 1248 Gambell across the street.

Violation of these rules may result in discharge from the program. Furthermore, if the safety of CHOICES, Inc. Staff and/or clients is threatened, the police will be called.

ACKNOWLEDGEMENT OF RIGHTS AND RESPONSIBILITIES

I _____ as an individual receiving services from CHOICES, do acknowledge that I have read, or have been read to, a copy of my rights. I also acknowledge that I have received a copy of said rights, understand their contents, and have been afforded the opportunity to ask any questions that I have concerning those rights and have received satisfactory answers to those questions.

Signature	Name	Date
Staff Signature	Staff Name	Date