AUTHORIZATION FOR RELEASE OF INFORMATION
(HIPAA COMPLIANT)

I hereby authorize Anka Behavioral Health, Incorporated to release to ________________________________,

located at ____

phone/ email____

or their authorized representative __________________________________, the information specified below pertaining to:
____ (Client's Name), Birthdate: ________________________,

Social Security Number: ___________________________

Name of Facility at which Client was seen: ____

The records are sought for the following dates: ____

This disclosure is requested for the purpose of: ____

☐ The request is made at the request of the Client
☐ The request is for use in a legal matter
☐ Other use: ____

Disclosure of Client Identifying Information to the public including, but not limited to a photo, video recording or other form of communication disclosing a Client's identity, name and likeness, association with an Anka Facility or Program and/or status of treatment.

Information/Type of Records Requested. Please check the applicable boxes:

☐ Psychiatric Records/Mental Health Records
☐ Alcohol and Drug Abuse Records
☐ Genetic Testing Records
☐ Diagnosis
☐ Discharge Summary
☐ HIV/Aids Report
☐ Laboratory Report(s)
☐ History and Physical
☐ Prognosis
☐ Billing Records
☐ Medication Records
☐ Clinical Test Results
☐ Physician Orders
☐ Treatment Plan
☐ Other Records Sought: ____

I further acknowledge that I understand my right to revoke this authorization by presenting written notice to Anka Behavioral Health, Incorporated. I further understand that if my authorization has been served on Anka Behavioral Health, Incorporated, Anka Behavioral Health, Incorporated has the right to dishonor my request to revoke the authorization.

This authorization expires on ____________________________.

I have read the above and also have been advised of my right to receive a true copy of this authorization. Further, I understand the contents of this written authorization in its entirety and have asked questions about anything that was to clear to me, and am satisfied with the answers I have received.

It should be further noted that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient.

A PHOTOSTATIC OR FACSIMILE COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIIVE AND VAILD AS THE ORIGINAL.

Client/Patient Signature: ____

Date: ____________________

If you are a former Client/patient not currently receiving treatment from Anka Behavioral Health, Incorporated, please attach a photocopy of your Driver's License/State Identification or other form of identification.

If you are not the Client/Patient, but a personal representative of the Client/Patient, please attach proof of the same to this authorization.

Representative Signature: ____

Relationship to Client/Patient: ____

Date: ____________________

IF APPLICABLE, COMPLETE THE FOLLOWING:

I specifically authorize the release of information pertaining to drug and alcohol abuse diagnosis or treatment (42 C.F.R. §§ 2.34 and 2.35), to mental health diagnosis or treatment (Welfare and Institutions Code §§ 5328 et seq.), to HIB/AIDS testing information (Health and Safety Code § 120980(g)), and to genetic testing information (Health and Safety Code § 124980(j)). I understand that such information cannot be released without my specific consent. I further understand that these records will be released under the same terms and conditions as set forth above.

Client/Patient Signature: ____

Date: ______________________

Representative Signature: ____

Relationship to Client/Patient: ____

Date: _______________________

(If an appointed Guardian, please attach documentation)