THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Health and Social Services

Division of Behavioral Health
Central Office

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# DIVISION OF BEHAVIORAL HEALTH (DBH)
# CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION
# (Medicaid Client Travel Form)

I, (name of patient)_____, authorize the following Substance Use Disorder treatment program(s) (name and address of each entity authorized to disclose and re-disclose information):

1. **Referring: _____**

2. **Receiving: _____**

3. **The following medical insurance provider:**

| | | |
|---|---|---|
| ☐ **(Conduent) Medicaid** | ☐ **YKHC** | ☐ **(ANTHC) Medicaid Travel** |
| **P.O. Box 240808** | **PO BOX 528** | **907-729-7720 Option 1 on the menu** |
| **Anchorage, AK 99524-0808** | **Bethel, AK 99559** | **When phone is answered, indicate that you are calling** |
| **907-644-6800 Fax: 907.644.5982** | **1-800-478-3321** | **in regard to DBH SUD travel** |
| | **Ext 6489 or** | |
| | **907-543-6489** | |

4. **and the Department of Health and Social Services Division of Behavioral Health (DBH), P.O. Box 110620, Juneau, Alaska, 99811-0620,**

**to communicate with and disclose to one another verbally, electronically, and/or in writing the following information**: the completed DBH or Medicaid Travel Request Form which contains my name, address, phone number, date of birth, Medicaid number, my diagnosis, my ASAM placement criteria, and whether or not I need an escort, my referral agency/counselor, my travel and admission dates, whether I am from a priority category, and why treatment is clinically appropriate for me.

The purpose of the disclosures authorized in this consent is to facilitate my travel to and from substance use disorder treatment.

I understand that my alcohol and/or drug treatment records are protected under the 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 CFR and cannot be disclosed without my consent unless otherwise provided for in the regulations. 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, and that in any event this consent expires automatically *upon completion of my substance use disorder treatment and subsequent return travel as needed.*

_____ _____
Signature of Client Date

_____ _____
Signature of Parent or Guardian Date