

**Alaska Department of Health
Division of Behavioral Health/ASAP**

PRIVACY NOTICE

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

ASAP's Duties

The Alaska ASAP System monitors misdemeanor substance abuse related offenses for the court. With releases of information ASAP can communicate and coordinate court cases statewide. This means that the Alaska ASAP system can exchange information between ASAP locations to facilitate the overall monitoring of your case(s). ASAP is required by law to maintain the privacy of your treatment information and to provide you with notice of its legal duties and privacy practices with respect to your treatment information. The following information will assist you in understanding your rights to privacy of information.

Please understand that generally the ASAP System may not condition your treatment/services on whether you sign a consent to release information form, but in certain limited circumstances services may be denied if you do not sign the consent form. **Failure to sign the ASAP release will cause your case to come to a stop and generate a report informing the referring agency of your decision.**

General Information

Information regarding your substance abuse treatment, including payment for treatment, is protected by two federal laws: the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. parts 160 & 164 and the Confidentiality Law, 42 C.F.R. Part 2. Under these laws, the Alaska Alcohol Safety Action Program (ASAP) System may not identify you as an alcohol or drug abuser or disclose any other protected information to anyone without your specific written permission except as permitted by federal law.

As per Alaska Administrative Code (7 AAC 80.210); ASAP is required to charge fees for each case ordered by the courts and or the DMV, reassigned by the courts and if opened / re-opened as a self referral by the clients choice. Also to be in compliance and or complete with ASAP all balances must be paid in full.

ASAP must obtain your written consent before it can disclose information about you. For example, ASAP must obtain your written consent before it can disclose information to a treatment agency that provides you with an assessment. However, federal law does permit ASAP to disclose information without written permission under the following conditions:

1. Pursuant to an agreement with a business associate;
2. For Research, audit or evaluation;
3. To report a crime committed on ASAP premises or against ASAP personnel;
4. To medical personnel in a medical emergency;
5. To appropriate authorities to report child abuse or neglect;
6. As allowed by a court order

Client initials: _____

For example, ASAP can disclose information without your consent to obtain legal or financial services, or to another medical facility to provide treatment to you, as long as there is a qualified service organization/business associate agreement in place.

Your Rights

Under HIPAA you have the right to inspect and copy your own treatment information maintained by the ASAP System, except to the extent that the information contains psychotherapy notes or information compiled for use in civil, criminal or administrative proceedings or in other limited circumstances. Under HIPAA you also have the right, with some exceptions, to amend health care information maintained in ASAP records, and to request and receive an accounting of disclosure (made after April 14, 2003) of your treatment related information for up to a six year period prior to your request. You also have the right to receive a paper copy of this notice.

ASAP is required by law to abide by the terms of this notice. ASAP reserves the right to change the terms of this notice and make new notice provisions effective for all protected treatment information it maintains. A copy of this change will be mailed to you within 30 days of the change.

You may contact ASAP and/or the Secretary of the United States Department of Health and Human Services if you believe that your privacy rights have been violated under HIPAA. A letter describing your complaint should be filed with the Alaska ASAP Program Coordinator at 303 K St., Anchorage, Alaska 99501, as soon as possible.

Violation of the Confidentiality Law by a program is a crime. Suspected violations of the Confidentiality Law may be reported to the United States Attorney in the district where the violation occurs.

A consent to release information is valid until you decide you want to stop the release of information process which is called revoking. A revocation must be in writing and means no further information may be released, however any information which has already been released cannot be recalled.

Contact

For further information contact the Alaska ASAP Program Coordinator at 303 K St., Anchorage, Alaska 99501. (907) 264-0735.

Your signature below indicates you have received a copy of this notice.

Client Signature

Date

Effective Date: April 24, 2003

**Alaska Department of Health
Division of Behavioral Health/ASAP
MULTIPLE CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION**

I, _____ DOB _____,

(Please Print legibly)

authorize the Alaska Alcohol Safety Action Program (ASAP) System to exchange verbal, written and electronic information with:

(Designate with your initials each agency or individual you are authorizing ASAP to communicate with)

____ 1. Alaska Court System

____ 2. Prosecuting Attorney

____ 3. Agency (Print agency name and phone) _____
(Name of agency)

____ 4. Personal Attorney (name and phone number) _____

____ Public Defender Agency ____ Denali Law Group (initials give permission for everyone in the PDA or DLG office)

____ 5. Interpreter or Individual (Print Name and phone number) _____

____ 6. Alaska Department of Corrections

The following information will be disclosed:

- | | |
|--|---|
| * My name and other personal identifying information | * Name of agency where I received treatment |
| * My status as a patient in alcohol and/or drug treatment | * Assessment/evaluation results |
| * Attendance and compliance with treatment | * Fee status for ASAP and referral agency |
| * Recommendations for further treatment services | * Drinker classification criteria |
| * Reports from collateral individuals or agencies | * Traffic and criminal record |
| * Discharge plan/summaries to include discharge dates & status | |
| * AKAIMS intake, consent, Episode, Miscellaneous ASAP notes regarding treatment service compliance | |

The purpose of this exchange, authorized by this consent, is to provide information to facilitate substance abuse education/treatment mandated by the court and/or prosecuting attorney

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 C.F.R. Pts 160 & 164 and **cannot be disclosed without my written consent unless otherwise provided for in the regulations.** I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically when there has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I am mandated to the Alaska ASAP system. I understand that if I choose to revoke this consent it must be in writing. I understand that health information covered by federal law 42 C.F.R. Part 2 Alcohol & drug abuse records prohibits any further disclosure of information that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 C.F.R. Part 2.

I understand that generally the ASAP System may not condition my services /treatment information on whether I sign this consent form, but in certain limited circumstances I may be denied ASAP services if I do not sign the consent form.

(Signature of client)

(Date)

(Signature of parent, guardian or
authorized representative when required)

(Description of Authorized Representative Authority)

Treatment agency written communication to Anchorage ASAP should be made to the attention of:
Louis Imbriani, ASAP Program Coordinator.

**Alaska Department of Health
Division of Behavioral Health/ASAP
DIVISION OF MOTOR VEHICLES CONSENT FOR RELEASE OF CONFIDENTIAL
INFORMATION**

I, _____ authorize the Alaska Alcohol Safety
(Please Print)

Action Program System (ASAP) to exchange information with the Alaska Division of Motor Vehicles (DMV) by providing the following information:

- * My name and other identifying information
- * My status as a patient in alcohol and/or drug treatment
- * Fee status for ASAP and referral agency

The purpose of this exchange is to provide information about my compliance with the requirements for the Alaska Division of Motor Vehicles.

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 C.F.R. Pts 160 & 164 and **cannot be disclosed without my written consent unless otherwise provided for in the regulations.** I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically when there has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I am mandated to the Alaska ASAP system. I understand that if I choose to revoke this consent the revocation must be in writing.

I understand that generally the ASAP System may not condition my services/treatment information on whether I sign this consent form, but in certain limited circumstances I may be denied ASAP services if I do not sign the consent form.

In order to comply with above federal regulations. I authorize ASAP and its agents to send a copy of the DMV correspondence to the following email address upon my request:

(Email Address)

I attest that I am the administrator of the email address and hold control over the account information and log in.

(Signature of client)

(Date)

(Signature of parent, guardian or
authorized representative when required)

(Description of Authorized Representative
Authority)

Date _____

ASAP CLIENT INTAKE FORM

ASAP File # _____

Name _____ Maiden Name _____ ADL # _____
First Middle Last

Gender: M / F (circle one) Date of Birth _____ Social Security # _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone: _____ Cell: _____ Email: _____

ETHNICITY-Check one

- ☐ Not Spanish/Hispanic/Latino Mexican
☐ Chicano/Other Hispanic
☐ Cuban
☐ Hispanic-Specific origin not specified
☐ Mexican American
☐ Puerto Rican
☐ Spanish/Hispanic/Latino

ENGLISH FLUENCY

- ☐ Excellent
☐ Good
☐ Moderate
☐ Poor
☐ Not at all

United States Citizen

- ☐ Yes ☐ No

If not U.S. Citizen, specify citizenship _____

State preferred language if other than English _____

Interpreter
Needed?

- ☐ Yes
☐ No

RACE(s)-Check all that apply

- ☐ Aleut
☐ Asian
☐ Athabascan (other than American Indian)
☐ Black/African American
☐ Caucasian
☐ Haida
☐ Inupiat
☐ Native Hawaiian
☐ Other Alaska Native
☐ Pacific Islander
☐ Tlingit
☐ Tsimshian
☐ Yupik
☐ Other _____

EDUCATION-Check One

- ☐ No schooling
☐ 1st grade
☐ 2nd grade
☐ 3rd grade
☐ 4th grade
☐ 5th grade
☐ 6th grade
☐ 7th grade
☐ 8th grade
☐ 9th grade
☐ 10th grade
☐ 11th grade
☐ GED
- ☐ High School Diploma (not GED)
☐ Vocational Training
☐ Special Ed. Ungraded Classes
☐ Bachelor Degree (BA or BS)
☐ Grad. Work No Degree
☐ Masters Degree
☐ Doctorate/Professional Degree
☐ Post Secondary - 1 yr.
☐ Post Secondary - 2 yrs.(incl. AA degree)
☐ Post Secondary - 3 yrs.
☐ Post Secondary - 4 yrs. No Degree
☐ Other _____

SPECIAL NEEDS

- ☐ Developmentally Disabled
☐ Fetal Alcohol Spectrum Disorder
☐ Major Difficulty in Ambulating or Non ambulation
(walking about)
☐ Moderate to Severe Medical Problems
☐ Organically Based Problem
☐ Severe Hearing Loss or Deaf
☐ TBI
☐ Visual Impairment or Blind
☐ Other _____
☐ None

VETERAN STATUS (Check all that apply)

- ☐ Never in Military
☐ Vietnam Era Vet; Combat
☐ Vietnam Era Vet; Non-Com
☐ Gulf War Vet; Combat
☐ Gulf War Vet; Non-Combat
☐ Afghan War Vet; Combat
☐ On Active Duty; Combat
☐ On Active Duty; No Combat
☐ Reserves or National Guard
Combat
☐ Reserves or National Guard; No-
Combat
- ☐ Retired f/Military;
Non-Combat
☐ Retired f/Military;
Combat
☐ Veteran, other Eras
☐ Military Dependent
☐ Not Applicable

Date _____

ASAP CLIENT INTAKE FORM

ASAP File # _____

Name: _____

MARITAL STATUS

- ☐ Single
☐ Married
☐ Separated
☐ Divorced
☐ Widowed

OCCUPATION/INDUSTRY

- ☐ Executive/Administrative Managerial
☐ Professional and Technical
☐ Marketing and Sales
☐ Administrative/Clerical Support
☐ Service Workers
☐ Mechanics/Installers/Repairers
☐ Construction/Trades
☐ Laborers/Equipment Cleaners
☐ Farmer/Fishing
☐ Other

EMPLOYMENT STATUS

- ☐ Employed
☐ Unemployed
☐ Retired

ANNUAL INCOME

- ☐ 0-\$9,999
☐ \$10,000-\$19,999
☐ \$20,000-\$34,999
☐ \$35,000-\$49,999
☐ \$50,000 or greater

OTHER REQUIREMENTS/AGENCIES

- ☐ None
☐ Mental Health Counseling
☐ Dual Diagnosis
☐ Parenting classes
☐ DOC/Probation
☐ OCS
☐ Anger Management
☐ Other

FAMILY HISTORY OF ALCOHOLISM

If Yes, check all that apply

- ☐ No history
☐ Mother
☐ Father
☐ Grandparents
☐ Relatives other than parents or grandparents

HISTORY OF BLACKOUTS

Most Recent

- ☐ Within past 3 months
☐ 3-6 months ago
☐ 6-12 months ago
☐ More than a year ago
☐ No History

PROBLEM WITH ALCOHOL or DRUGS

- ☐ Yes
☐ No
☐ Maybe

PRIOR SUBSTANCE ABUSE EDUCATION OR TREATMENT HISTORYAgency & LocationDates AttendedCompleted?

- | | |
|--|----------|
| ☐ ADIS/Education _____ | Yes / No |
| ☐ Outpatient _____ | Yes / No |
| ☐ Intensive Outpatient _____ | Yes / No |
| ☐ Aftercare _____ | Yes / No |
| ☐ Inpatient/Residential _____ | Yes / No |
| ☐ Other _____ | Yes / No |

CRIMINAL HISTORY OUTSIDE OF STATE OF ALASKAState/Charge/Date of OffenseConvicted?State/ Charge /Date of OffenseConvicted?

- | | | | |
|-------|----------|-------|----------|
| _____ | Yes / No | _____ | Yes / No |
| _____ | Yes / No | _____ | Yes / No |
| _____ | Yes / No | _____ | Yes / No |