

# BRISTOL BAY NATIVE ASSOCIATION

P.O. BOX 310  
DILLINGHAM, ALASKA 99576  
PHONE (907) 842-5257



Aleknagik

Chignik Bay

Chignik

Lagoon

Clarks Point

Curyung

Egegik

Etuk

Ekwok

Igiugig

Iliamna

Ivanof Bay

Karatak

King Salmon

Kokhanok

Koltganek

Levelock

Manokotak

Naknek

New Stuyahok

Newhalen

Nondalton

Pedro Bay

Perryville

Pilot Point

Port Heiden

Portage Creek

South Naknek

Togiak

Twin Hills

Ugashik

Dear Consumer:

Enclosed is an application and releases of information for the Bristol Bay Native Association Vocational Rehabilitation. Please complete and sign the application and releases of information and returned them via mail or fax back to:

**Vocational Rehabilitation  
Workforce Development  
P.O. Box 310  
Dillingham, AK 99576**

**Fax 907-842-3498**

This information is requested so that our agency may determine eligibility for Vocational Rehabilitation Services.

**Please provide the following documentation with application:**

*Completed and Signed application.*

*Signed and dated releases of information.*

*A copy of tribal enrollment card.*

*Tribal Enrollment Number Verification form (If No Tribal Enrollment Card).*

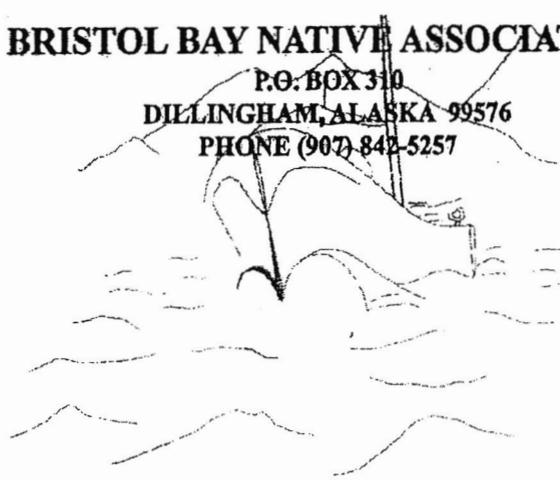
If you have any questions, please feel free to call (907) 842-2262 or 1-888-285-2262.

Thank you,

Bristol Bay Native Association, Vocational Rehabilitation Program.

# BRISTOL BAY NATIVE ASSOCIATION

P.O. BOX 310  
DILLINGHAM, ALASKA 99576  
PHONE (907) 842-5257



## Bristol Bay Native Association, Vocational Rehabilitation Program

Bristol Bay Native Association's Vocational Rehabilitation Program helps Alaska Natives and Native Americans who live in the Bristol Bay Region obtain, maintain, or advance in employment. BBNA's Vocational Rehabilitation Program is designed to provide culturally relevant services to consumers.

### Vocational Rehabilitation can help you:

- Enter the work force.
- Keep current employment.
- Advance in employment
- Return to work based on your strengths, resources, priorities, abilities, capabilities, interests and informed choices.

### What are the requirements for eligibility?

You must meet *all* of the requirements below:

- You must be an Alaska Native or Native American with enrolled in a Federally Recognized Tribe.
- You must have a physical or mental disability which results in a substantial impediment to employment.
- You must require Vocational Rehabilitation Services to prepare for, enter, engage in or retain gainful employment.
- You must live within the service area (Bristol Bay Region).

### What happens if I apply?

A review and assessment of existing data relating to your disability will be conducted by the Vocational Rehabilitation Counselor. If the records are insufficient, current evaluations will be conducted to help determine eligibility and the scope of vocational rehabilitation services.

### If I am eligible, then what?

You and the Vocational Rehabilitation Counselor will discuss your abilities and interests. In addition, your needs, transferable skills and other special work skills will be assessed. Following the needs assessment, your employment opportunities will be discussed. A review and assessment of existing data relating to your disability will be conducted by the Vocational Rehabilitation Counselor.

The next step will be the development of an Individualized Plan for Employment (IPE). You will be given information to make choices regarding what vocational rehabilitation services you will use, who will provide those services and how to obtain them.

*Aleknagik*

*Chignik Bay*

*Chignik*

*Lagoon*

*Clarks Point*

*Curyung*

*Egegik*

*Ekuk*

*Ekwok*

*Igiugig*

*Iliamna*

*Ivanof Bay*

*Kanatak*

*King Salmon*

*Kokhanok*

*Koliganek*

*Levelock*

*Manokotak*

*Naknek*

*New Stuyahok*

*Newhalen*

*Nondalton*

*Pedro Bay*

*Perryville*

*Pilot Point*

*Port Heiden*

*Portage Creek*

*South Naknek*

*Togiak*

*Twin Hills*

*Ugashik*

**What are my responsibilities?**

A successful job placement requires cooperation between you and the Vocational Rehabilitation Counselor. To overcome barriers to employment, you must have the desire to participate and use other supportive services to complete your vocational rehabilitation plan and.

Alaska Natives and Native Americans with disabilities living in Dillingham can obtain vocational rehabilitation services at BBNA Work Force Development. The Vocational Rehabilitation staff provides outreach services to 32 villages in the Bristol Bay Region.

**A glance at the VR Process:**

1. Application
2. Assessment
3. Eligibility (written documentation)
4. Individual Plan for Employment
5. Provision of Services
6. Employment
7. Follow along during employment if needed
8. Closure
9. Post employment services

**Examples of disabilities VR services are provided for include:**

Alcohol & Drug Addiction  
Amputations  
Visual Impairments  
Hearing & Speech Impairments  
Mental Retardation  
Mental Illness  
Orthopedic Problems  
Seizure Disorders  
Traumatic Brain Injury  
Learning Disabilities  
Diabetes  
other physical or mental conditions that limit one's ability to work or function.

**All services are strictly confidential.**

**Toll free 1-888-285-2262**

**(907) 842-2262**

**Bristol Bay Native Association  
Tribal Vocational Rehabilitation Program**

**Application for Vocational Rehabilitation Services**

Name: \_\_\_\_\_  
(Last) (First) (Middle) (Preferred)

Previous Name(s): \_\_\_\_\_  
(Last) (First) (Maiden)

SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Gender: \_\_\_\_ [F] \_\_\_\_ [M] Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_ City, State, Zip code: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City, State, Zip code: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_  
(Circle any that apply) Voice / TDD / Fax / Cell / Msg (circle any that apply) Voice / TDD / Fax / Cell / Msg

E-Mail Address: \_\_\_\_\_  
(TVR does not guarantee confidentiality of e-mail communication. By providing an e-mail address, you are authorizing TVR to correspond with you via e-mail.)

**\*\*\* Please provide TVR with a copy of your tribal enrollment card. \*\*\***

**Certification**

I have been provided the following information:

- An overview of the TVR process,
- Services offered by TVR,
- My rights as a TVR applicant or client,
- My responsibility as a TVR applicant or client,
- TVR's confidentiality policy,
- The process of appealing decisions made by TVR and
- An explanation and brochure on the Client Assistance Program (CAP).

The above topics have been explained to me at the time of orientation/intake with TVR.

I understand the rights and responsibilities I have as an applicant/participant of the TVR and am willing to abide by them.

By signing this application, I am requesting services from the Bristol Bay Native Association TVR. I further certify that the information provided on this application and the Participant Information Questionnaire (attached) is correct. I understand TVR may use my name and social security number with the Social Security Administration to verify the status of any Social Security benefits I may be receiving. I further understand that medical doctors under contract with TVR may review my medical information.

Participant/Representative Name(s) (Printed) \_\_\_\_\_

Participant/Representative Signature(s) \_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please mark you level of education:**

- |   |   |
|---|---|
| <input type="checkbox"/> No Formal Schooling            | <input type="checkbox"/> High School Diploma or Equivalency Certificate |
| <input type="checkbox"/> Elementary Education (1-8)     | <input type="checkbox"/> Post Secondary Education- no Degree            |
| <input type="checkbox"/> High School- no Diploma (9-12) | <input type="checkbox"/> AA degree or Vocational/Technical Certificate  |
| <input type="checkbox"/> Currently in High School       | <input type="checkbox"/> Bachelors Degree                               |
| <input type="checkbox"/> Special Education Certificate  | <input type="checkbox"/> Masters Degree                                 |

**Please mark your employment situation for the past 30 days:**

- |   |   |
|---|---|
| <input type="checkbox"/> Competitive labor market                               | <input type="checkbox"/> Homemaker                    |
| <input type="checkbox"/> Competitive labor market with supports                 | <input type="checkbox"/> Trainee, intern or volunteer |
| <input type="checkbox"/> Sheltered workshop or community rehabilitation program | <input type="checkbox"/> Unpaid family worker         |
| <input type="checkbox"/> Self-employed  | <input type="checkbox"/> High school student          |
| <input type="checkbox"/> Business Enterprise Program                            | <input type="checkbox"/> All other students           |

If you are currently working, the weekly earnings for the past week \_\_\_\_\_  
the number of hours you worked during the past week \_\_\_\_\_

**Employment History (most recent jobs first) or attach Resume:**

Employer: \_\_\_\_\_ Location: \_\_\_\_\_  
Job Title/Duties: \_\_\_\_\_  
Dates of employment: \_\_\_\_\_ Reason for Leaving: \_\_\_\_\_

**Employment History (most recent jobs first) or attach Resume:**

Employer: \_\_\_\_\_ Location: \_\_\_\_\_  
Job Title/Duties: \_\_\_\_\_  
Dates of employment: \_\_\_\_\_ Reason for Leaving: \_\_\_\_\_

**Employment History (most recent jobs first) or attach Resume:**

Employer: \_\_\_\_\_ Location: \_\_\_\_\_  
Job Title/Duties: \_\_\_\_\_  
Dates of employment: \_\_\_\_\_ Reason for Leaving: \_\_\_\_\_

**Employment History (most recent jobs first) or attach Resume:**

Employer: \_\_\_\_\_ Location: \_\_\_\_\_

Job Title/Duties: \_\_\_\_\_

Dates of employment: \_\_\_\_\_ Reason for Leaving: \_\_\_\_\_

**Employment History (most recent jobs first) or attach Resume:**

Employer: \_\_\_\_\_ Location: \_\_\_\_\_

Job Title/Duties: \_\_\_\_\_

Dates of employment: \_\_\_\_\_ Reason for Leaving: \_\_\_\_\_

Do you have a valid Social Security Card? Yes  No

Do you have a valid Alaska driver's license? Yes  No

Do you have your own transportation? Yes  No

Have you ever been convicted of a DWI? Yes  No

Have you ever been convicted of a crime? Yes  No

If yes, please explain: \_\_\_\_\_

Are you currently on probation or parole? Yes  No

Do you have any additional considerations, such as language interpreters, or environmental concerns that we can accommodate? \_\_\_\_\_

I am requesting services from BBNA Vocational Rehabilitation for the following disability/problems:

\_\_\_\_\_

I am interested in the following types of services from BBNA Vocational Rehabilitation:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is the disability a result of an industrial injury? Yes  No

If yes, date of accident \_\_\_\_\_ Employer: \_\_\_\_\_

Insurance Adjuster \_\_\_\_\_ Phone Number: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever applied for vocational rehabilitation services before? Yes  No

If yes, where? \_\_\_\_\_ When? \_\_\_\_\_

Please list any personal doctors/hospitals who are familiar with your condition:		
Name	Address	Last Seen

Medications you are currently taking: \_\_\_\_\_

Any type of treatment you are currently receiving: \_\_\_\_\_

Are you able to travel unassisted? \_\_\_\_\_

Are you receiving personal care attendant services? Yes  No  If yes, hours/day \_\_\_\_\_

**Please check any of the following health insurance or coverage you have available:**

Medicare  Through your own employment

Medicaid  Other private insurance such as through your spouse

Indian Health Services, VA  None

Sliding Fee Scale

**Please indicate if you are receiving any of the following and the monthly amount:**

<p>SSDI</p> <p><input type="checkbox"/> Applicant Allowed \$ _____</p> <p><input type="checkbox"/> Applicant Denied</p> <p><input type="checkbox"/> Applicant Status Pending</p> <p><input type="checkbox"/> Benefits Dsicontined or Teminated</p> <p><input type="checkbox"/> Not an Applicant</p>	<p>SSI</p> <p><input type="checkbox"/> Applicant Allowed \$ _____</p> <p><input type="checkbox"/> Applicant Denied</p> <p><input type="checkbox"/> Applicant Status Pending</p> <p><input type="checkbox"/> Benefits Dsicontined or Teminated</p> <p><input type="checkbox"/> Not an Applicant</p>
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VA	\$	_____	APA	\$	_____
ATAP/TANF	\$	_____	Workers' Compensation	\$	_____
Other Disability	\$	_____	Other/Unemployment	\$	_____
General Assistance	\$	_____	WC	\$	_____

**Please Indicate how you found out about Vocational Rehabilitation:**

<input type="checkbox"/> High School	<input type="checkbox"/> Self-referred
<input type="checkbox"/> Physician or Medical Facility	<input type="checkbox"/> Newspaper
<input type="checkbox"/> Community Rehabilitation Program	<input type="checkbox"/> VR Staff
<input type="checkbox"/> One-stop Employment Center	<input type="checkbox"/> Tribal Council
<input type="checkbox"/> College	<input type="checkbox"/> All other sources
<input type="checkbox"/> Welfare Agency	<input type="checkbox"/> Agency
<input type="checkbox"/> Social Security	<input type="checkbox"/>

**Bristol Bay Native Association  
Tribal Vocational Rehabilitation  
P.O. Box 310  
Dillingham, AK 99576  
Phone: (907)842-2262 Toll Free: 1-888-285-2262 (In State Only)  
Fax: (907)842-3498**

**AUTHORIZATION FOR RELEASE OF PERSONAL INFORMATION**



I hereby request and authorize you to release to the Bristol Bay Native Association Vocational Rehabilitation the following types of informaton, which you have pertaining to me.



I hereby authorizing the Bristol Bay Native Association Vocational Rehabilitation to release to you the specified information requested.

**This consent is subject to revocation (in writing) at any time except to the extent that action has been taken thereon.**

Complete below Date and Initial each information source					
Information	Date	Initial	Information	Date	Initial
School Transcripts			Hospital Records		
Other Academic Information			Psychosocial Evaluation		
Psychological Testing			Financial Information		
Consumer Publicity Release			Past Employment Records		
Psychiatric Evaluations			Alcohol or Drug Abuse		
Native Blood Quantum			Medical Records/ Reports		

**(Optional) This release of information will expire without expressed revocation on:**

1 year

\_\_\_\_\_  
Parental or Guardian Signature

\_\_\_\_\_  
Consumer Printed Name

\_\_\_\_\_  
Consumers' maiden name (or any name used)

\_\_\_\_\_  
Consumer Signature

\_\_\_\_\_  
"X" If unable to sign

\_\_\_\_\_  
DOB:

\_\_\_\_\_  
Witness and Date

If a consumer is a minor, signature of a Parent or Guardian is required. If unable to write His or Her name, the consumer should enter an "X" or other mark.

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Phone: (907)842-2262 Toll Free: 1-888-285-2262 (In State Only)  
Fax: (907)842-3498**

**Parental/Guardian Permission Release of Information**

\_\_\_\_\_  
Consumer's Name

\_\_\_\_\_  
Parent or Guardian

\_\_\_\_\_  
P.O. Box #

\_\_\_\_\_  
P.O. Box #

\_\_\_\_\_  
City      State      Zip

\_\_\_\_\_  
City      State      Zip

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Date of Birth

**I give my child the permission to participate in the Vocational Rehabilitation Program. This may include, but is not limited to:**

1. Evaluation (s): including a physical exam, vocational testing, etc., to determine eligibility for vocational rehabilitation services.
2. Work experience programs, which may or may not be on school grounds.
3. Employment when my child completes the school program.

I understand the Vocational Rehabilitation Program will not interfere with and will not take the place of the educational program of the school, but will work in conjunction with the school program.

I also understand that I will be notified about the eligibility of my child for vocational rehabilitation services and about any rehabilitation services planned for my child.

Parents are invited and strongly encouraged to share their opinions and goals regarding their child's work potential and future.

\_\_\_\_\_  
Parent or Guardian's Signature

\_\_\_\_\_  
Date

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Tribal Vocational Rehabilitation  
P.O. Box 310  
Dillingham, AK 99576  
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Fax: (907)842-3498**

### **Similar Benefits for Services/Training**

#### **Criteria of Eligibility for Rehabilitation Services**

You are eligible for vocational rehabilitation services when it has been determined that:

1. You have a physical or mental disability which for you constitutes or results in a substantial handicap employment, and
2. You can reasonably be expected to benefit in terms of employability from vocational services.

#### **Criteria of Acceptance for Extended Evaluation Services**

You are eligible for extended evaluation when it is determined that:

1. You have a physical or mental disability which for you constitutes or results in a substantial handicap to employment, and we are a **Drug and Alcohol free service provider**.
2. It is not possible to determine that you can benefit from services in terms of employability without an extended evaluation.

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#### **Criteria For Implementation And Continuation Of The Individualized Plan for Employment (IPE).**

##### **Counselor Responsibility**

1. Consults with the consumer regarding any significant changes to the program.
2. Provides follow-up services to ensure completion of the program insofar as possible.
3. Provides opportunity for review of this program at least quarterly.
4. Works with consumer in a professional and ethical manner consistent with BBNA VR policy.

## Consumer Responsibility

1. Makes all reasonable efforts to reach the intermediate objectives and vocational goal.
2. Maintains satisfactory grade and other requirements of the training facility.
3. Maintains contact with the counselor to report progress in the program, including providing copies of grades and transcripts, and reporting changes of financial/or living circumstances.
4. Keeps all appointments with the counselor and other scheduled aspects of the program.
5. Cooperates and follows through with medical and other professional instructions.
6. To apply for and use other sources of money to pay for what you need. For example, you might apply for a Pell grant to go to school. Or you might use health insurance for medical care. Your counselor will help you with this.
7. Notifies the counselor when employed and gives details of employment.

## Consumer Rights

1. You are to be fully consulted regarding any significant changes to your program.
2. You may discuss a problem or grievance with the counselor at any time.
3. If at anytime you are dissatisfied with any decision made by BBNA VR, you have the right to an administrative review.
4. You are advised of the Client Assistance Program (CAP)
5. You are provided the opportunity to participate in periodic and annual reviews of the program.
6. You are to be provided the opportunity to participate in any ineligibility decisions.
7. Title VI SEC. 601 of the Civil Rights Act of 1964 states, "No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."
8. All information BBNA VR secures about you is voluntary but not necessary to accomplish your rehabilitation and **will be kept confidential**. It will be released only to government or private organizations involved in your rehabilitation. (34 CFR 369.46)

## **Change And Termination**

The jointly developed program does not represent a legal obligation for BBNA VR and is subject to change on the basis of finding that reasonable likelihood of achieving employability no longer exists. If the agency initiates a change to the rehabilitation plan, you will be notified prior to the effective date of change.

## **Certification**

I understand my rights and responsibilities as a consumer stated above.

---

Consumers Signature

---

Date

**ALASKA NATIVE MEDICAL CENTER**

4315 Diplomacy Dr. Anchorage, AK 99508

Email: [akahimroiteam@anmc.org](mailto:akahimroiteam@anmc.org) Phone: 907-729-3019 Fax: 907-729-3001



**AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

<b>PATIENT</b>	<b>Name:</b> _____ <b>Birth Date:</b> ____/____/____ <b>Other Names Used:</b> _____															
<b>FROM</b>	<b>I request patient's information be sent by:</b> <input type="checkbox"/> Alaska Native Medical Center (Alaska Native Tribal Health Consortium & Southcentral Foundation) <input type="checkbox"/> Another health care provider name here: _____															
<b>PROVIDE TO</b>	<b>Who do you want the patient information to be sent to?</b> <b>Name:</b> _____ <b>Phone Number:</b> _____ <b>How do you want the medical information to be sent?</b> <input type="checkbox"/> It will be picked up. <input type="checkbox"/> Mail to this address: _____ <input type="checkbox"/> Fax to: _____ * <input type="checkbox"/> Email to: _____ * <input type="checkbox"/> Other (describe): _____ <small>*Sending information by Fax or Email increases privacy risks, as they involve increased risk of accidental disclosure. Information sent electronically may also be vulnerable to cyber attack.</small> <b>Record Format:</b> <input type="checkbox"/> Paper <input type="checkbox"/> Disc <input type="checkbox"/> Other: _____ <i>Note: If no selection is marked, paper records are mailed.</i>															
<b>REQUESTED INFORMATION</b>	<b>Please check or describe the health information that you would like disclosed:</b> <table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> Consultations</td> <td><input type="checkbox"/> Discharge Summaries</td> <td><input type="checkbox"/> History &amp; Physical Exams</td> </tr> <tr> <td><input type="checkbox"/> Medications Records</td> <td><input type="checkbox"/> Physician Reports</td> <td><input type="checkbox"/> Nursing Notes</td> </tr> <tr> <td><input type="checkbox"/> Laboratory Results</td> <td><input type="checkbox"/> Pathology Reports</td> <td><input type="checkbox"/> Radiology &amp; Imaging Reports</td> </tr> <tr> <td><input type="checkbox"/> Immunization Record</td> <td><input type="checkbox"/> EKG Reports</td> <td><input type="checkbox"/> Emergency Dept. Records</td> </tr> <tr> <td><input type="checkbox"/> Complete Record</td> <td><input type="checkbox"/> Sleep Study</td> <td><input type="checkbox"/> School Physical</td> </tr> </table> <input type="checkbox"/> Records for the following dates or treatment: _____ <input type="checkbox"/> Other: _____ <b>Specific Sensitive Information needs to be initialed to be disclosed:</b> ___Mental/Behavioral Health Treatment ___Drug/Alcohol Abuse ___HIV/AIDS Information ___STD Treatment	<input type="checkbox"/> Consultations	<input type="checkbox"/> Discharge Summaries	<input type="checkbox"/> History & Physical Exams	<input type="checkbox"/> Medications Records	<input type="checkbox"/> Physician Reports	<input type="checkbox"/> Nursing Notes	<input type="checkbox"/> Laboratory Results	<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Radiology & Imaging Reports	<input type="checkbox"/> Immunization Record	<input type="checkbox"/> EKG Reports	<input type="checkbox"/> Emergency Dept. Records	<input type="checkbox"/> Complete Record	<input type="checkbox"/> Sleep Study	<input type="checkbox"/> School Physical
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<input type="checkbox"/> Immunization Record	<input type="checkbox"/> EKG Reports	<input type="checkbox"/> Emergency Dept. Records														
<input type="checkbox"/> Complete Record	<input type="checkbox"/> Sleep Study	<input type="checkbox"/> School Physical														
<b>PURPOSE</b>	<b>Why are you requesting this disclosure?</b> <input type="checkbox"/> Personal Use <input type="checkbox"/> Legal <input type="checkbox"/> State/Federal <input type="checkbox"/> Insurance/Benefits <input type="checkbox"/> Care Coordination <input type="checkbox"/> School <input type="checkbox"/> Other: _____															
<b>VALIDITY</b>	<b>Expiration:</b> This authorization will expire one (1) year from the signature date, unless an alternative expiration date is provided here: ____/____/____ <b>Revocation:</b> An authorization may be revoked at any time by written notice to ANMC Health Information Management. Revocation is not effective until notice is received and is not effective regarding disclosures made before revocation and where authorization was obtained as a condition of insurance coverage.															
<b>PATIENT RIGHTS</b>	I understand that: (1) I have a right to receive a copy of this signed authorization upon request; (2) I have a right to refuse sign this authorization - ANMC may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on a decision to sign this form; and (3) I have a right to inspect or copy my health information. I may arrange to inspect or copy information maintained by ANMC by contacting Health Information Management. I may be charged a reasonable fee for copying costs.															
<b>REQUESTOR</b>	I authorize the disclosure of health information described above. Information released under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal privacy standards, including HIPAA and the Privacy Act of 1974. A photo copy/fax of this form is as valid as the original.  <b>Signature:</b> _____ <b>Date:</b> ____/____/____ <b>Print Name:</b> _____ <b>Relationship to Patient:</b> <input type="checkbox"/> Self <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Legally Authorized Representative <input type="checkbox"/> Other: _____ <b>Mailing Address:</b> _____ <b>City:</b> _____ <b>State:</b> _____ <b>ZIP:</b> _____ <b>How should we contact you if there are questions?</b> <input type="checkbox"/> Phone: _____ <input type="checkbox"/> Email: _____															



# Bristol Bay Area Health Corporation

6000 Kanakanak Road, PO Box 130  
Dillingham, AK 99576  
907-842-9352 or toll free 800-478-5201 ext 6352  
Fax: 907-842-9315

## Authorization to Disclose Health Care Information

### Patient Information

Please **PRINT** all information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone number: \_\_\_\_\_

### Health Care Information

I, \_\_\_\_\_, hereby authorize the **Bristol Bay Area Health Corporation** to disclose my health care information/records as described below to the person or organization listed below.

Name of Person or Organization: BBNA Tribal Vocational Rehabilitation  
Organization's Address: P.O. Box 310, Dillingham, AK 99576  
Phone / Fax: 907.842.2262 / 907.842.3498

**For the purpose(s) of:** Receiving assistance from BBNA Tribal Vocational Rehabilitation Program.

### Release the following health care information

(You must check at least one box in this section and supply the information or **NO** health care information can be released.)

#### My Health Care Information and Records concerning;

The following treatment or condition: \_\_\_\_\_  
 Treatment I received during the following dates: From: \_\_\_\_\_ To: \_\_\_\_\_  
 Other (including billing information): \_\_\_\_\_  
(Please describe) (Please describe)

Please initial to authorize the information listed below to be used, disclosed, or received:

\_\_\_ Mental Health \_\_\_ HIV/AIDS \_\_\_ Drug / alcohol / tobacco abuse diagnosis, prognosis, or treatment\*

Information to be disclosed (describe how much, and what kind): \_\_\_\_\_

The above information will not be disclosed unless specifically authorized.

\* The following notice accompanies a disclosure of health information concerning an individual in alcohol/drug abuse treatment made with the authorization or consent of such individual:

"This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."



# Bristol Bay Area Health Corporation

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Fax: 907-842-9315

## Authorization to Disclose Health Care Information

### Patient Information

Please **PRINT** all information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
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#### My Health Care Information and Records concerning;

The following treatment or condition: \_\_\_\_\_  
 Treatment I received during the following dates: From: \_\_\_\_\_ To: \_\_\_\_\_  
 Other (including billing information): IHS-Billing  
(Please describe) \_\_\_\_\_ (Please describe) \_\_\_\_\_

Please initial to authorize the information listed below to be used, disclosed, or received:

\_\_\_ Mental Health \_\_\_ HIV/AIDS \_\_\_ Drug / alcohol / tobacco abuse diagnosis, prognosis, or treatment\*

Information to be disclosed (describe how much, and what kind): \_\_\_\_\_

The above information will not be disclosed unless specifically authorized.

\* The following notice accompanies a disclosure of health information concerning an individual in alcohol/drug abuse treatment made with the authorization or consent of such individual:

"This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."

**Termination of Authorization**

*(Check one box in this section and fill in blanks or nothing can be released.)*

**This authorization ends:**

In 1yr days from the date this was signed       On the date of: \_\_\_\_\_       When the following occurs: *(Please describe.)* \_\_\_\_\_

**Acknowledgment:** *(Please read and sign).*

I acknowledge and understand that I may revoke this authorization at any time by notifying the Bristol Bay Area Health Corporation (BBAHC) Privacy Officer on the designated form, except to the extent that action has been taken in reliance upon this authorization. BBAHC’s Notice of Privacy Practices also describes how this authorization may be revoked. I may cancel this authorization at any time using any of the following:

- 1. Sign and date a “Revocation of Authorization” form, available from Bristol Bay Area Health Corporation.
- 2. Write, sign, and date a letter to Bristol Bay Area Health Corporation, Attn: Privacy Officer, PO Box 130, Dillingham, Alaska 99576 stating that I want to cancel this authorization.

I acknowledge and understand that if I do cancel or otherwise end this authorization, my act of canceling this authorization will not effect any actions or disclosures already taken based on my original authorization.

I acknowledge and understand that once Bristol Bay Area Health Corporation gives out my health care information as authorized by this document, Bristol Bay Area Health Corporation has no control over it. If the person or entity authorized to receive the above-described information is not a health care provider or health plan covered by federal or state privacy laws, then the information used, disclosed, and received under this authorization may be subject to redisclosure and no longer be protected by those laws. Federal or state law, however, may restrict redisclosure of mental health, drug/alcohol abuse, and HIV/AIDS information unless I specifically authorize redisclosure.

I may refuse to sign this authorization. My refusal will not adversely affect my ability to receive treatment, payment for services, enrollment in a health plan, or eligibility for benefits, except if this authorization is sought for purposes of: research-related treatment; determining my eligibility or enrollment in a plan; underwriting or risk determinations; or providing health information to someone else and such services are solely for such purpose.

I received a copy of this authorization. I may inspect or request copies of information disclosed by this authorization.

I have been advised that my treatment, payment, enrollment, or eligibility for benefits is not and cannot be conditioned on my signing this authorization and I sign this authorization with the knowledge that I am not required to sign it in order to receive treatment.

\_\_\_\_\_  
Signature of **Patient** \_\_\_\_\_  
Date

\_\_\_\_\_  
**Patient Name Printed**

*Requested by Legally Authorized Representative\*\**

\_\_\_\_\_  
**Signature** of Legally Authorized Representative\*\* \_\_\_\_\_  
**Printed Name** of Legally Authorized Representative\*\*

\_\_\_\_\_  
Address of requesting party **if different than patient’s** \_\_\_\_\_  
Phone Number of requesting party

*\*\*If this authorization is being signed by the Legally Authorized Representative of the Patient, the person signing this form must state the grounds for their authority to act on the Patient’s behalf, as well as provide documentation to that effect.*

**Grounds for authority:** \_\_\_\_\_

**For BBAHC Use Only:**

Date Request Received: \_\_\_\_\_ Date Access Provided: \_\_\_\_\_  
Name and Title of BBAHC member processing request: \_\_\_\_\_  
Verification method: \_\_\_\_\_ Chart #: \_\_\_\_\_ Log #: \_\_\_\_\_