AUTHORIZATION FOR RELEASE OF INFORMATION
ALASKA PSYCHIATRIC INSTITUTE

Return Address: Health Information Management Services, Alaska Psychiatric Institute, 3700 Piper St, Anchorage, Alaska 99508
Phone: (907) 269-7100 Fax #: (907) 269-7129

Section 1

I, _____ DOB: _____ SS#: _____
hereby authorize:

Alaska Psychiatric Institute (Name of Person/Agency)	X ☐ To Release to	_____ (Name of Person/Agency)
3700 Piper Street (Address)	X ☐ To Exchange with	_____ (Address)
Anchorage Ak 99508 (City, State, Zip Code)	x ☐ Exchange Verbal Information	_____ (City, State, Zip Code)

Section 2

The following specific information:

X Admission Assessment/Data Base	x Social History	x Lab
x Discharge Summary	x History & Physical	x X-Ray
x Nursing Assessment	x Psychological Evaluation	x Rehabilitation Assessments
____Other: _____		

for care received from: _____ to Date of Discharge

Section 3

The purpose of the release of this information is:

X ☐ Sharing with other health care providers as needed ☐ My personal records ☐ Legal
☐ Other – Please specify _____

I understand that the information in my health record may include information relating to acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. Exchange of information ensures continuity of care between providers. By not sharing information, my health care could be compromised.

I hereby authorize the use or disclosure of my health care and/or other information as described above. I understand that this authorization is voluntary. I understand that I may revoke this authorization at any time by notifying the individual(s) or organization releasing this information in writing, but if I do, it won't have any affect on actions taken on this authorization before my revocation was received. I understand that the individual(s) or organization releasing this information will not condition my treatment, payment, enrollment in a health plan (if applicable) or eligibility for benefits on whether I provide this authorization. I understand that if the person(s) or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential.

This authorization expires on the following date or event: 1 year from signature date or 90 days from the date of signature if no other date or event is indicated.

_____ / _____ / _____
(Signature of Witness) (Date/Time) (Signature of Patient/Guardian) (Date/Time)

NOTE: This authorization was revoked on: _____
(See reverse side or attached revocation)

_____ / _____
(Relationship to Patient) (Date/Time)

RECIPIENT INFORMATION: If the information released pertains to alcohol or drug abuse, the confidentiality of the information is protected by federal law (CFR 42 Part 2) prohibiting you from making any further disclosure of this information without the specific written authorization of the person to whom it pertains or as otherwise permitted by CFR 42 Part 2. A general authorization for the release of medical or other information if held by another party 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.

Patient Identification

Authorization for Release of Information,
API Form 06-9003. Rev. 04-03, 09-03, 6-10, 2-16 HIPAA Compliant

PATIENT DIRECTORY FORM

Alaska Psychiatric Institute

PATIENT DIRECTORY CHOICE

1. **API has a patient directory to serve patients and their family, relatives and friends.**
2. **I understand I have the choice whether or not to be listed on the API patient directory.**
3. **IF I have a Guardian, I understand my Guardian is legally required to make &/or approve my choice.**
4. **If I choose YES, I will be on the patient directory**, and my name, my unit's name and my unit phone number can be given to people who call or come to API if they ask for me by name.
5. **If I choose NO, I will NOT be on the patient directory**, and all visitors and phone calls (except people listed below) will be told, "There is no one by that name listed in our patient directory." Also, all mail, flowers or other deliveries sent for me (except from people listed below) will be sent back.
6. **CHECK ONE BOX:** ☐ **YES**, list me on patient directory.
   ☐ **NO**, do not list me on patient directory.
   ☐ **Patient unable** to complete form and has no Guardian/Personal Representative. Per P&P, **list patient on Patient Directory**.

CONTACT LIST

Name of Visitor	Relationship	Name of Visitor	Relationship
1)		5)	
2)		6)	
3)		7)	
4)		8)	

SIGNATURES:

Patient Signature _____ Date _____ Signature➔ ☐ Legal Guardian or ☐ Personal Representative _____

PRINT NAME of Legal Guardian or Personal Representative _____ Description of Personal Representative's Authority _____

ASO Signature (or RN if after patient admitted) _____ PRINT NAME of ASO (or RN) _____ Date _____

DISTRIBUTION / ROUTING OF FORM:

◆ **At Time of Admission & When Making Changes** ➔ YELLOW Copy to Comm. Center. WHITE Copy to Medical Record.

IF PATIENT WANTS TO MAKE CHANGES TO CONTACT LIST OR PATIENT DIRECTORY

If patient wants changes to Contact List above, and /or first chose to be off Patient Directory but now wants to be on the directory, then a New form must be filled out and signed by patient, Guardian and RN, and routed as above.

Patient Identification

AUTHORIZATION FOR NOTIFICATION OF ARRIVAL FORM

ALASKA PSYCHIATRIC INSTITUTE

I, _____, hereby authorize the Alaska Psychiatric Institute (API) to notify the below listed individual of my admission to API. I understand that this authorization is limited only to providing a person of my choosing with:

1. Date and time of my admission to API;
2. Name of the unit I have been admitted to; and
3. API's phone number.

Additionally, I understand that I have a right to refuse Notification of Arrival. This authorization does not take the place of an Authorization for Release of Information (API Form# 06-9003) and by signing below, information from my medical record will not be released. If I would like to have my records released, Authorization for Release of Information forms are available to me on the unit.

☐ I would like API to notify a person of my choosing of my admission to API

☐ I decline the Notification of Arrival

Name of Person to Contact:_____

Relationship to Patient:_____

Phone Number:_____

_____ _____

(Patient Signature) (Date)

_____

(ASO Signature)

Patient Identification

NOTICE OF RIGHTS DURING COURT-ORDERED EVALUATION

Respondent's Name: _____

The court received a petition alleging that you have a mental illness that causes you to be gravely disabled or likely to harm yourself or others. The court ordered that you be hospitalized for up to 72 hours so you can be evaluated by a mental health professional and a medical doctor.

This notice explains your rights while you are hospitalized for evaluation.

COMMUNICATION

The court appointed a lawyer from the Public Defender Agency to represent you. Contact the Public Defender Agency at (800) 478-4404 or (907) 334-2580, or at one of the numbers below:

- Anchorage (855) 334-2580 or (907) 334-2580
- Fairbanks (800) 478-1621 or (907) 458-6800
- Juneau (800) 478-4910 or (907) 465-4911
- Ketchikan (800) 478-6189 or (907) 228-8950
- Palmer (800) 478-5661 or (907) 707-1710

You may also hire your own lawyer at your own expense.

You have the right to immediately speak with your lawyer, your guardian (if you have one), your parent (if you are a minor), and another adult of your choice. The government must pay any costs of contacting these people. Your guardian (if you have one) will be told about your rights. You can request that another adult of your choice be told about your rights too.

TRANSPORT

If you are not already there, you will be transported to a crisis residential center or evaluation facility, depending on the type of court order you have. If you are not transported to this facility right away, the court will receive a daily status report explaining:

- where you are
- why there is a delay in transporting you
- why it is necessary to keep you detained while you are waiting for transport

You may call your lawyer to request a court hearing about your transport status. If your condition improves while you wait for transport, the holding facility may determine that you no longer meet the legal standard to be detained involuntarily. If this happens, they will file a dismissal of your case with the court and you will have the right to leave.

The time you are waiting for transport does not count toward the 72-hour time limit.

EVALUATION AND COURT HEARING

Once you arrive at the crisis residential center or evaluation facility, you must be examined and evaluated within 72 hours (the 72-hour period does not include Saturdays, Sundays, or legal holidays). You must be released after this evaluation if the legal standard for holding you involuntarily is not met. If the evaluators recommend that you stay longer in the facility for treatment, you may voluntarily agree to this. If you do not agree to the recommended treatment, you have the right to a court hearing.

The court hearing will be scheduled to happen no more than 72 hours after you arrive at the crisis residential center or evaluation facility. If the end of the 72 hours falls on a Saturday, Sunday, or legal holiday, the hearing will be scheduled for the next business day.

Notice to Parents or Guardians of Minor Respondents

You have the right to proceed as a party in this case. You have the right to your own attorney to represent you. If you cannot afford an attorney, you may request that the court appoint you one at public expense by filing *Request for Appointed Attorney* (form P-910). This form is available from the court clerk, or online at https://public.courts.alaska.gov/web/forms/docs/p-910.pdf.

☐ I, _____, orally notified the respondent of these rights, and I gave a copy of this notice form to the respondent on _____.
☐ I, _____, notified the respondent's parent/guardian of these rights and of the respondent's location at this facility on _____.

ACKNOWLEDGEMENT OF RECEIPT
API NOTICE OF PRIVACY PRACTICES

Printed Name of Client/Patient _____ Date/Time _____

Please indicate that you have received a copy of the API Notice of Privacy Practices by checking below and signing your name*.

—— (initial) Acknowledgement that I have received API's Notice of Privacy Practices.

—— (initial) Acknowledgement of facility use of video surveillance system.
The undersigned acknowledges that Alaska Psychiatric Institute uses closed circuit television monitors, including video and audio recording in public areas and limited patient care areas (not bedrooms or bathrooms) of our facilities. This monitoring is to enhance patient safety and security. This surveillance does not compromise privacy in any way.

Signature of Client/Patient or Personal Representative* (Or Witness if signature is by mark) Date/Time _____

Printed Name of Personal Representative or Witness _____

Description of Personal Representative's Authority Date/Time _____

* Personal Representative signature required if client/patient is a minor or adult who is unable to sign this form.

API STAFF ONLY: This portion to be completed by API staff ONLY if unable to obtain client/patient acknowledgement signature above. Indicate the reason acknowledgement was not obtained by checking the appropriate box, entering other information (if necessary) and print staff name.

An attempt was made to obtain acknowledgement for receipt of API Notice of Privacy Practices. Acknowledgement was not obtained because:

[ ] Client/Patient declined to sign acknowledgement
[ ] Other: (explain) _____

Printed Name of API Staff _____ Date/Time _____

Patient Identification

Alaska Psychiatric Institute

Patient and Family Guide On the Use of Seclusion or Restraint

First, we want you to know how we define "Family." We are very inclusive, and for us "family" includes any person who plays a significant role in the patient's life; the person does not have to be legally related to the patient. Examples could include a parent, spouse, significant other, child, friend, foster parent, guardian, etc.

Confidentiality regulations protect the privacy of the patient. For adult patients (age 18 and older), API staff may not contact the family or release patient information to the family without the permission of the adult patient.

What is API's policy on the use of seclusion or restraint?

It is the policy of Alaska Psychiatric Institute (API) to treat all patients in the least restrictive environment that is consistent with each individual patient's requirements for treatment and safety. The patient has the right to be free from seclusion or restraint. A seclusion or restraint procedure is only used as last resort, when other treatment and safety approaches have been unsuccessful.

- When a seclusion or restraint procedure is ordered, the person is closely monitored using constant observation by an assigned staff member, with continuous assessment of the patient throughout the procedure.
- A medical restraint procedure is used only to allow for a patient's medical evaluation or treatment. An example of a medical restraint procedure is, if needed, holding someone's arm briefly for a blood sample so that necessary laboratory testing can be done.
- API does not use seclusion or restraint procedures as a means of coercion, discipline, punishment, convenience, or in retaliation by staff, or as a substitute for a less restrictive form of treatment or interventions.

How does staff help patients to avoid the use of a seclusion or restraint procedure?

Before resorting to the use of a seclusion or restraint procedure, API staff will attempt a variety of less-restrictive methods to calm or distract a patient from unsafe and injurious behaviors. These methods may include:

- ✓ Spending time alone to talk with the patient.
- ✓ Offering quiet space for the patient to be alone (a "Time-Out," which is voluntary).
- ✓ Offering activities that interest the patient.
- ✓ Providing a different bed area.
- ✓ Providing exercise opportunities.
- ✓ Suggesting that the patient call a friend or family member to talk.
- ✓ Offering medications for anxiety or agitation when needed.
- ✓ Explaining to the patient how his or her behavior is unsafe.

ADVANCE DIRECTIVE INFORMATION

DEAR HEALTH CARE CONSUMER:

On December 1, 1991, all nursing homes, hospitals, hospices, and providers of home health care or personal care services who receive funding from Medicaid or Medicare must inform you of your right to make "advance directives," and the Alaska State Laws which apply to these directives. This requirement is part of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90). The Department of Health and Social Services for the State of Alaska has prepared this information for you, to help you understand your right and the law. If you don't completely understand this information, or have other questions, ask your health care provider.

WHAT IS AN ADVANCE DIRECTIVE?: As a consumer of health care, you have the right to be informed about and take part in deciding what treatments you receive and those you don't want to receive. You now have an additional right guaranteed to you to say in advance what kind of treatment you want or do not want under special, serious medical conditions. This kind of information is what we mean when we say "advance directive." The two ways you can make an advance directive in Alaska are by completing a "Living Will" or a "Durable Power of Attorney" or both, and are described below.

WHAT IS A LIVING WILL?: A living will is a written declaration or statement telling your physician or other health care provider that you do not wish for your life to be prolonged by life-sustaining procedures if you are determined to be terminally ill and are unable to make your decision. This is called a "living will" because it takes effect while you are still living. Under Alaska law, your living will takes effect when your condition is determined to be terminal and when you become unable to make your own decision. It is your responsibility to give a copy of your living will to your physician.

Once a physician or other health care provider receives a copy of your living will, it becomes a part of your permanent medical record at that location. Make sure you fill out your living will completely, following all instructions.

CAN I CHANGE MY MIND?: Yes. You can change or withdraw any or all of your living will any time you want. The Alaska law states you can do this in any way you are able to communicate, without regard to your mental or physical condition. This change or withdrawal is only effective once you or someone you have told communicates your wishes to your attending physician or health care provider. Once your physician or health care provider becomes aware of these changes, the changes or revocation becomes a part of your permanent medical record at that facility.

WHAT IF I HAVE A LIVING WILL FROM ANOTHER STATE?: The Alaska law states that as long as your living will meets all the laws or other requirements from the state where the living will was made, it will be acceptable and honored in Alaska. It may be advisable, however, to fill out a new living will, especially if you spend time in more than one state.

WHAT IS A DURABLE POWER OF ATTORNEY FOR HEALTH CARE?: Many of us are familiar with a power of attorney which is a legal document used to give someone else or more than one person the authority to act in our behalf. Usually this includes the power to transact business and sign things in our name. Powers of attorney can also be granted for someone to make health care decisions on our behalf.

- Keep the original or a second copy of your advance directive in a safe place where it can be easily found, if it is needed.

- Keep a small card in your purse or wallet, which states that you have an advance directive, where it is located, and who your representative is, if you have named one.

IS MY HEALTH CARE PROVIDER REQUIRED TO DO ANYTHING AS A RESULT OF THIS LAW?: Yes. Your health care provider must do the following:

1. Provide you written information concerning your rights under Sate law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

2. Provide you written information concerning your health care provider's policies and procedures about what their practices are when someone has an advance directive.

   Under Alaska law, a physician who is unwilling to comply with your advance directives, must withdraw as attending physician but the withdrawal is effective only when the services of another attending physician have been obtained.

   If the polices of the health care facility are that they cannot honor your advance directives, they must notify you, and take all reasonable steps to transfer you home or to another facility where your directives can be carried out.

3. Upon notification that you have advance directives, the facility must include them in your permanent medical record.

4. Comply with all regulations and State laws for advance directives.

5. Provide for education on advance directives to staff and the community.

ATTACHMENT: As noted

As a Participant of the Medicaid and Medicare, this facility agrees to protect and promote each of the rights listed below:

1. To be informed of rights before furnishing or discontinuing patient care, when possible
2. To establish a grievance procedure and inform each patient who to contact to file a grievance
3. To participate in the development and implementation of one's own plan of care
4. To make informed decisions regarding one's own care
5. To formulate and advance directive
6. To have a family member or chosen representative be notified promptly of admission
7. To personal privacy
8. To receive care in a safe setting
9. To be free from harassment, physical or mental abuse, or corporal punishment
10. To confidentiality of one's own clinical information
11. To access information contained in one's own clinical records within a reasonable timeframe
12. To be free from restraints or seclusion of any form imposed as a means of coercion discipline, convenience or retaliation by staff
13. To safe implementation of restraint or seclusion by trained staff
14. Federal law provides consumers the right to reasonable access to treatment regardless of race, sex, creed, marital status, national origin, handicap or age.
15. To receive or deny visitors of your choosing and be informed of any clinical restriction or limitation of that right. In order to protect privacy, rights and safety of yourself and others, the facility may restrict the available time and place of visitation.

If you have questions or concerns about your rights, you may contact one of the following organizations:

Disability Law Center of Alaska (DLC)-800-478-1234
Office of Children's Services-800-478-4444
Adult Protective Services-800-478-9996
State of AK, Facility Licensing & Certification-888-387-9387
Joint Commission-800-994-6610
AK State Ombudsman-907-269-5290
National Alliance on Mental Illness-907-272-0227
Center for Medicare & Medicaid Svc-866-226-1819 800-633-4227
Public Defender Office-907-334-2580
Quality Improvement Organization-KEPRO Region 10-888-305-6759

Steps To Appeal Your Discharge

- **Step 1**: You must contact the QIO no later than your planned discharge date and before you leave the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
  - Here is the contact information for the QIO:

Name of QIO (in bold)
KEPRO Region 10
Telephone Number of QIO
888-305-6759

  - You can file a request for an appeal any day of the week. **Once you speak to someone or leave a message, your appeal has begun.**
  - Ask the hospital if you need help contacting the QIO.
  - The name of this hospital is :

Hospital Name	Provider ID Number
Alaska Psychiatric Institute	K0000ZBBBB

- **Step 2**: You will receive a detailed notice from the hospital or your Medicare Advantage or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.
- **Step 3**: The QIO will ask for your opinion. You or your representative need to be available to speak with the QIO, if requested. You or your representative may give the QIO a written statement, but you are not required to do so.
- **Step 4**: The QIO will review your medical records and other important information about your case.
- **Step 5**: The QIO will notify you of its decision within 1 day after it receives all necessary information.
  - If the QIO finds that you are not ready to be discharged, Medicare will continue to cover your hospital services.
  - If the QIO finds you are ready to be discharged, Medicare will continue to cover your services until noon of the day after the QIO notifies you of its decision.

If You Miss The Deadline To Appeal, You Have Other Appeal Rights:

- You can still ask the QIO or your plan (if you belong to one) for a review of your case:
  - If you have Original Medicare: Call the QIO listed above.
  - If you belong to a Medicare Advantage Plan or other Medicare managed care plan: Call your plan.
- If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048.

Additional Information: or email: AltFormatRequest@cms.hhs.gov .