



Set Free Alaska's Children's Program

Referring Agency

Application

i.e., Office of Children's Services, Guardian Ad Litem

This packet has been made to be printed double sided.

If your packet is incomplete, we will not be able to review your application.

Please make sure to complete the packet in its entirety. Before files can be reviewed, we will also need any pertinent collateral if there is OCS or other court involvement.

Please be sure to complete all documents.

1. Client Profile Form
2. Behavioral Health Intake Form
3. Consent to Treatment for a Minor
4. Release of Information (ROI) for the parent(s), legal guardian(s), and/or foster parent(s)
5. Release of Information (ROI) for Office of Children's Services caseworker and/or another referring agency and representative

If you have any questions, please contact our office 907-921-5818.

Fax: 907-290-3808

When you have completed this packet, please scan and email it to office@setfreealaska.org or drop it off in person at our office.

Thank you.



- I understand I must have valid ID before the day of my assessment or I will be rescheduled. _____
Initial
- Completion of this form is required before assessment. Please note Set Free Alaska does not serve sex offenders at this time.* _____
I understand Initial

Client Profile

1. Client Name (First and Last): _____

IF FEMALE MAIDEN NAME IS REQUIRED _____

Parent or guardian Name (If Applicable) _____

2. Date of Birth: _____

3. Social Security Number: _____

4. Phone Number: Cell: _____ Home: _____

5. Email: _____

6. Physical Address: Street, Apartment _____

City, State, Zip _____

7. Mailing Address: Street, Apartment _____

City, State, Zip _____

8. Client Gender Male OR Female

9. Required if Female: Pregnant: YES OR NO If yes: DUE DATE ____/____/____

Injection Drug User (In Past 12 Months): CIRCLE ONE YES OR NO

10. Race: (Please circle all that apply)

Aleut American Indian Asian Athabascan Black/African American
Caucasian Haida Inupiat Native Hawaiian Other Alaska Native
Pacific Islander Tlingit Tsimshian Yupik Other: _____

11. Ethnicity: (Circle One)

Spanish/Hispanic/Latino/Mexican Chicano/Other Hispanic Cuban Not Hispanic Specific Origin Mexican American
Spanish/Hispanic Latino Puerto Rican Not Specified

12. Living Arrangements: (Check One)

- | | | | |
|---|--|--|--------------------------------------|
| ☐ Assisted Living | ☐ Correction Detention Facility | ☐ Crisis Residence | ☐ Foster Care |
| ☐ Group Home | ☐ Halfway House | ☐ Homeless | ☐ Shelter |
| ☐ Residential Treatment | ☐ Therapeutic Foster Care | ☐ Transitional Housing | ☐ Unknown |
| ☐ Hospital for Psychiatric Purposes | | ☐ Nursing Home | ☐ Other |
| ☐ Private Residence with supportive services | | ☐ Private Residence without supportive services | |

13. Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Cohabiting ☐ Separated ☐ Single

14. Do you use tobacco? ☐ Yes ☐ No What type? (Cigarettes/ Cigars/ Smokeless/ Pipe)

15. English Fluency: ☐ Excellent ☐ Good ☐ Moderate ☐ Poor ☐ None

16. Interpreter Needed? ☐ Yes ☐ No

17. Military Status: ☐ Never in Military ☐ Reserves/National Guard ☐ Active Duty ☐ Retired ☐ Veteran ☐ Combat

18. Referral Source: _____

19. Employment Status: (Circle one)

Employed Full Time	Not in Labor Force, Inmate	Retired	Student
Employed Part Time	Not in Labor Force, Not Seeking Work	Seasonal in Season	Disabled
Homemaker	Not in Labor Force, Subsistence	Seasonal, Out of Season	
Unemployed, Seeking Work	Unemployed, not Seeking Work	Not in Labor Force: Other: _____	

List your Profession/Work/Experience/Skills/Trade:

Professional/Managerial Sales	Service/Household Laborer/Not farm	Crafts/Operatives	Farm Owner/Laborer
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20. Education: ☐ HS Diploma Or ☐ GED ☐ BA/BS Degree ☐ AA Degree ☐ Masters Degree
☐ Highest Grade Level _____

21. Household Composition: (Circle One)

Lives Alone	Lives with Adolescents	Lives with Children	Lives with Non-Relatives
Lives with Relatives	Lives with Significant Other	Lives with Significant Other and Children	
Other			

Number of People Living with You: _____ Number of Children: _____

Number of Children in Residential Setting Receiving Services: _____

Number of Legal Dependents: _____

22. Annual Household Income: (Circle One)

0-999	1,000 - 4,999	5,000 - 9,999	10,000 - 19,999	20,000 - 29,000	
20,000-29,000	30,000 - 39,000	40,000 - 49,000	50,000 - 59,000	60,000 to 74,999	above 75,000

23. Legal Status: (Circle one)

None/No Involvement	180 Day Commitment	30 Day Commitment	90 Commitment
Case Pending	Community Sentencing	Deferred Prosecution	Informal Probation
Emergency Commitment	Incarcerated	Office of Children's Services	Probation/Parole
Court Ordered for Observation and Evaluation		Court Ordered for Mental Health Treatment	
Court Ordered Juvenile (INT) Parents Retain Custody		Court Ordered Juvenile (INT), DJJ Custody	
Court Ordered for Alcohol Treatment		Title 12-Not Guilty by Reason of Insanity	

Number of Arrests in the past 30 days: _____

24. **Presenting Problem(s) in clients own words (Why are you seeking our services?):**

25. Please identify your primary source of income: (Circle One)

None	Tribal Assistance Program	AK Native Corporation Dividend	Public Assistance/Welfare
Alimony	Alaska PFD	Child Support	Parent's Income
Employment	Interest and Other	Other	Social Security
Social Security Disability	Self Employed	Railroad Retirement	Unemployment Compensation
Spouse/Significant other	Retirement/Survivor/Disability Pension		SSI

26. Please identify your expected payment Source : (Circle One)

Aetna	Medicaid
AK Native Health Care	Medicare
Blue Cross/Blue Shield	No Charge
CIGNA	Other Government Grant Other Native Health Care
Client Self Pay	Other Private
HMO	Sliding Scale; client partial payment
Indian Health Services	Sliding Scale, No Charge Other Public
	Other: _____

27. Number of Prior Substance Abuse Admissions : _____

28. Number of Non-Treatment Substance Abuse Related Hospitalizations in the past six months: _____

29. Number of times you have attended a self-help program in the last 30 days. Including AA, NA, and other self-help / mutual support groups focused in recovery from substance abuse dependence: (Check One Below)

___ No attendance in the past month. ___ 1-3 times in the past month. ___ 4-7 times in the past month. ___ 8-15 times in the past month.
___ 16-30 times in the past month. ___ Some attendance, but frequency unknown. ___ Unknown. ___ Not Collected

In case of emergency Set Free Alaska Staff has my permission to notify any of the following persons:

Name: _____

Phone# _____ **Cell#** _____

Relationship: _____

Name: _____

Phone# _____ **Cell#** _____

Relationship: _____

By signing and submitting this form, I am giving consent to Set Free Alaska to enter my identifying information into the appropriate electric health recording system(s).

INITIAL:

____ I understand that the information in this correspondence may contain information relating to my substance use diagnosis and/or treatment, mental health diagnosis and/or treatment, and/or Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS)

____ I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug 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 the agencies identified above may not condition my treatment on whether I sign a consent form, but that in certain circumstances I may be denied treatment if I do not sign a consent form.

____ I understand and consent to the use of all electronic communication, text messaging and email and that they all have potential security risks.

____ I consent for Set Free Alaska to verify my health insurance coverage.

SIGNATURE OF CLIENT

PRINT NAME

DATE

**SIGNATURE OF PARENT,
GUARDIAN OR REPRESENTATIVE**

RELATIONSHIP TO CLIENT

DATE



Set Free Alaska
Behavioral Health Intake Form
Child and Adolescent Outpatient Program

History of Presenting Problem

Child's Name: _____ DOB: _____ Age _____

Form completed by: ☐ Parent ☐ Foster Parent ☐ Guardian ☐ Other: _____

Referred by: ☐ Parent/Guardian ☐ OCS ☐ The Children's Place ☐ Doctor
☐ Other _____

Child's chief reason for needing help at this time.

How long has your child had these symptoms, problems or issues?

Has your child received treatment for these issues in the past? ☐ Yes ☐ No

If yes, when was the last time they were in treatment and who were they receiving treatment from?

Has your child ever had inpatient mental health treatment? ☐ Yes ☐ No

If yes, please give a brief description of treatment dates, facility name and outcomes.

Describe the impact your child's current behavioral/emotional struggles are having on the family.

Describe your child's unique qualities and strengths.

Is there any current legal involvement that may have an impact on your child? Please check all that apply:

☐ Custody ☐ Adoption ☐ Probation ☐ Visitation ☐ Child Protective Services
☐ Other _____

If yes, briefly describe:

Behavior Checklist Please check all that apply within the past six months

Behavior	X	Behavior	X
Crying, sadness, depression		Hallucinations	
Verbalizing a wish to die		Strange or unusual behavior	
Isolation/Withdrawal		Low motivation	
Worries more than others		Twitches or unusual movements	
Nightmares, night terrors		Wanting to run away	
Bedtime fears		Sneaks out at night	
Bed wetting		Self-injuries	
Soiling (pooping) in pants		Self-induced vomiting	
Sleep difficulties, too much or too little		Binge eating	
Hyperactivity		Self-starvation	
Frequently acts without thinking		Blames others for own mistakes	
Does not finish things		Stealing	
Easily distracted		Lying	
Often caught daydreaming		Hurts animals	
Has habits or rituals		Destroys property	
Temper outbursts		Hurts people	
Irritability		Drug use	
Frequent arguing		Alcohol use	
Does things to annoy others		Tobacco use	
Anxious/Nervous		Problems with authority	
Unusual fears or phobias		Sexual Problems	

Developmental History

During pregnancy, did mother:

☐ Drink ☐ Drugs ☐ Illness ☐ Accident ☐ Victim of Domestic Violence

☐ Pregnancy Related Problems ☐ Complications with Labor/Delivery

If yes, please describe

Did child meet all of their developmental milestones on time?

☐ Sitting Up ☐ Crawling ☐ Walking ☐ Feeding Self ☐ Toilet Training ☐ Talking

☐ Dressing Self ☐ Sleeping Through the Night

Briefly explain any delays:

Medical HistoryIs your child currently under the care of a physician or psychiatrist? ☐ Yes ☐ No

If yes: Doctor's Name: _____ Phone Number: _____

Treatment for: _____

Is your child currently taking any medications? ____ Yes ____ No If yes, include the following information:

Names of Medications

Dosage

Prescribed by

_____	_____	_____
_____	_____	_____

Please indicate if your child has had any of the following: Check and describe

X	Condition	Age	Description
	Major Illness		
	Serious Infection		
	Head Injury		
	Hospitalization		
	Surgeries		
	Ear Infection		
	Poisoning		
	Allergies		
	Asthma		
	Vision Impairment (glasses or contacts)		
	Hearing		

Does your child have any other medical conditions? ____ Yes ____ No

If yes, please explain:

Are your child's immunizations up to date? ____ Yes ____ No

Does your child frequently complain of body aches and pains? ____ Yes ____ No

If yes, please describe:

Does your child miss school because of his/her physical complaints? ____ Yes ____ No

If yes, please describe:

Interpersonal Relationships Check each item that describes your child:

	Yes	No		Yes	No
Is shy			Fights with others		
Prefers to be alone			Is demanding/bossy		
Has many friends			Bullies others		
Has a few friends			Plays with kids their own age		
Is picked on a lot			Conflicts with parents/guardian		
Is often alone, but desires friends			Poor peer relationships		
Respect for authority			Excessive conflicts with siblings		

Education

Where does your child attend school? _____

Does your child have an Individualized Learning Plan (IEP)? _____

Has your child repeated a grade? ____ yes ____ No

Does your child often get discipline referrals, or detention? ____ Yes ____ No

Has your child been suspended this school year? ____ yes ____ No

Family Life

Please list all of the people who currently live with your child

Name	Age	Relationship

What are your family supports? (friends, church etc.)

What are your family strengths?

Forms of discipline used in the home: ____ Time Out ____ Incentives/Rewards ____ Grounding

____ Loss of Privileges ____ Extra Chores ____ Physical/corporal punishment

Other: _____

Please list any family history of mental illness.

Current Family Stressors Check all that apply:

Family Stressor	X	Family Stressor	X
Financial problems		Legal issues	
Divorce		Death of a relative	
Job loss		Death of a friend	
Parents using drugs/alcohol		Family illness	
Housing problems		Custody disputes	

Please list any other stressors not mentioned above.



Haven Behavioral Health Informed Consent to Treatment

Acknowledgment of Informed Consent

I acknowledge that I have received, read (or had read to me), and understand the information provided regarding the therapy I am considering for my myself/my child offered by Set Free Alaska (SFA). I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I consent for myself and/or to allow my child, _____, to take part in behavioral health services.

About the Therapy Process

Before beginning therapy, it is important to understand that the therapeutic process has both benefits and risks. Therapy often involves discussing difficult life events, emotions, behaviors, and experiences. As a result, some children and adolescents may experience temporary discomfort, including feelings of fear, sadness, anger, frustration, or loneliness. There may also be short-term increases in emotional or behavioral challenges.

Research supports the effectiveness of therapy for children and adolescents. Although specific outcomes cannot be guaranteed, potential benefits may include:

- Reduction in emotional and behavioral difficulties
- Improved emotional regulation
- Increased self-esteem and coping skills
- Improved family relationships and communication
- Enhanced social functioning and resilience

Treatment approaches may include individual child therapy, family therapy, cognitive behavioral therapy (CBT), social skills development, client-centered therapy, play therapy, expressive arts therapy, animal-assisted interventions, family navigation, case management, SUD care coordination and other evidence-based therapeutic modalities.

Provider Credentials and Supervision

I understand that clinical services are provided by a variety of professionals including licensed clinicians, masters level clinicians, certified counselors, provisional addiction professionals, peer support, licensure candidates, behavioral health technicians and interns operating within their professional scope of practice. All professionals providing services receive regular supervision within the scope of their position. All interns and licensure candidates receive clinical supervision. Credentials are available upon request. I understand that licensure candidates may be under clinical supervision with an entity external to SFA. In these instances, it is understood that all client information will be de-identified in compliance with CFR 42 part 2 and HIPPA regulations.

Confidentiality

The confidentiality of all counseling interactions is protected by Federal law. Information shared in therapy is considered privileged and will be kept confidential except under the following circumstances:

- Medical emergencies
- Threat of harm to self or others
- Mandatory state reporting such as reasonable suspicion of child abuse, neglect, abandonment, or exploitation or of dependent adult or elder abuse
- Court orders or other legal mandates
- Third-party billing and healthcare operations
- Receipt of valid written authorization

Releases of Information (ROI) are documents that give permission for SFA to share specific information about the client's treatment or specific clinical documents with individuals and/or agencies such as (Office of Children's Services or an attorney's office). Minors over the age of ten receiving SUD assessment or treatment services and their legal guardian both must sign a ROI for it to be valid to release information to an agency or individual outside of SFA. Minors and their legal guardians have the right to refuse to sign an ROI, refuse to authorize the release of any information, and have the right to revoke authorization of the release of information at any time.

Parent & Guardian Involvement

Parents are encouraged to respect their minor child's right to confidentiality, in order to help the minor to feel safe and to build a trusting relationship with the therapist. Parents should be informed that in working with children/adolescents special care and sensitivity will be given to such topics as substance abuse and sexuality. The therapist may encourage the child/adolescent to share critical information and will help them to do this with their parent/guardian, but we will not do so ourselves unless it is necessary to protect the wellbeing or life of the minor child or someone else.

Parents/guardians are encouraged to provide relevant information to the therapist at least 24 hours prior to scheduled sessions to allow appropriate clinical planning.

Custody/Guardianship

Consent for services can only be authorized by the current legal guardian. For divorced, or legally separated parents' consent may be given by the parent authorized to make medical decisions. If parents hold joint custody regarding medical decisions, consent of both parents is required. Documentation of custody arrangements must be provided and maintained in the client record.

In any custodial arrangement, both parents have the right to contact the therapist and inquire regarding their child's treatment progress (unless otherwise indicated by the courts).

As a general guideline, Set Free Alaska Clinicians will not make recommendations to the court concerning parenting issues or custody. SFA clinicians do not provide custody evaluations or make recommendations regarding parenting arrangements.

The Haven clinical team may work with Office of Children's services on reunification cases.

Client Rights and Responsibilities

Parents/guardians and minor clients have the right to:

- Ask questions and receive clear explanations of services and therapeutic techniques
- Participate in treatment planning, treatment decisions, and periodic review and revision of your treatment plan
- Refuse specific therapeutic techniques
- Be informed of potential consequences of refusing treatment
- Discontinue therapy at any time (financial responsibility remains for services rendered)
- Receive referrals upon request
- Request copies of medical and billing records

I agree to:

- Participate actively in treatment
- Follow program rules and safety guidelines
- Treat staff and peers respectfully
- Maintain confidentiality of others
- Follow all federal and state laws and regulations
- Take my medications as prescribed

I understand that:

- Set Free Alaska uses a third-party operator, Mirah for data collection that is intended to support tracking progress. I also understand that this is HIPPA and CFR 42 part 2 compliant and that I can opt out at any time for my child.
- The supervised visitation service at SFA is different than counseling. Supervised visitation is offered as a support to fulfilling my Office of Children Services (OCS) case plan. I understand that I must have a current ROI between OCS and Set Free Alaska, that allows for the sharing of supervised visit notes to participate in supervised visitation.
- I must call to cancel an appointment for myself and/or my child at least 24 hours in advance. I acknowledge that continually showing up more than 5 minutes late for appointments or ongoing no-shows may result in my child being discharged from therapeutic services.
- The program may have a Therapy Animal that might be present during group and/or individual counseling sessions.

Financial Responsibility and Insurance Authorization

I agree that I am financially responsible for services provided until the termination of treatment. I authorize insurance providers and third-party payers to receive information necessary for billing, including service types, dates, costs, and providers.

Clinical Team Model & Training Programs

I understand that SFA uses a multidisciplinary treatment team and may involve interns and licensure candidates in treatment delivery under supervision. For external supervision, client data will be de-identified in compliance with confidentiality laws.

Safety, Surveillance, and Facility Policies

I acknowledge:

- Set Free Alaska utilizes websites and views collateral for such purposes as reviewing legal history.
- Personal belongings in the outpatient facility need to be under the direct control of their owner at all times.
- SFA does not use seclusion or restraint.
- All facilities utilize continuous video surveillance for safety and security.
- Smoking, vaping and chewing tobacco are allowed only in the designated outdoor smoking area in compliance with State of Alaska law.
- Weapons, drugs, alcohol and, or drug paraphernalia of any kind are prohibited.
- Visitors must check in and sign confidentiality agreements and are required to comply with all rules of the facility.
- Emergency preparedness drills are required.
- Staff direction must be followed during emergencies.

Medication Management

I agree to and/or have my child follow all medication management policies and procedures of the program including:

- bringing prescribed medications in for counting/review by staff upon request
- providing information for all medications at admission
- promptly informing clinical staff of any changes in medications
- taking all prescription medications as prescribed and according to written instructions

I authorize program staff and prescribing providers to coordinate care, verify prescriptions, communicate with outside pharmacies and healthcare providers as necessary, and implement appropriate medication management practices to support my safety and treatment progress.

I understand that Set Free does not administer, maintain, or control my own or my child's prescription medication in any manner.

Alcohol & Drug Testing

I agree that the identified client (myself and/or my child) will submit to random and requested alcohol and drug screenings as part of my treatment plan and program participation.

I understand that SFA utilizes Millennium Health Laboratory for toxicology testing. Mine or my child's private insurance and/or Medicaid information will be provided to Millennium Health for billing purposes. If I am self-pay, I understand that I will receive a separate bill directly from Millennium Health.

I understand that I may be required to obtain drug testing for myself and/or my child through a local laboratory at my own expense if directed by program staff.

I understand that my own or my child's refusal to submit to a drug or alcohol screen, whether conducted onsite or at a designated laboratory within the required timeframe, will be considered a failed test and may result in clinical intervention, behavioral contract, modification of services, or discharge from the program.

I understand that if my own or my child's screening results indicate the presence of alcohol or drugs for which no legitimate medical explanation can be provided, my child may be subject to disciplinary action, modification of my treatment plan, or discharge from the program.

I understand that screening results may be shared with other agencies or individuals only as required by law or as permitted through properly executed consent forms, in compliance with 42 CFR Part 2, HIPAA, and applicable state and federal regulations.

Voluntary Activities & Liability Waiver

I understand that Set Free Alaska offers optional recreational, vocational, and experiential activities, which may include but are not limited to:

- Outdoor fires and campfire activities
- Fishing trips
- Community outings
- Gym and fitness center use
- Construction, maintenance, and building projects
- Recreational sports and outdoor activities

Participation in these activities is completely voluntary and is not required as a condition of treatment.

Acknowledgment of Risk

I understand that my own or my child's participation in these activities may involve inherent risks, including but not limited to:

- Physical exertion
- Uneven terrain
- Exposure to weather
- Use of tools and equipment
- Potential injury, illness, or accident

I voluntarily assume all risks associated with my own and/or my child's participation. I will and will ensure my child complies with all medical recommendations and manufacturer recommendations on any equipment I or my child uses.

Release and Waiver of Liability

In consideration of being permitted to participate in these activities, I hereby release, waive, discharge, and hold harmless Set Free Alaska, its directors, officers, employees, volunteers, contractors, and affiliates from any and all claims, demands, damages, actions, or causes of action arising out of or related to any loss, damage, or injury that may be sustained by me while participating in voluntary activities, except in cases of gross negligence or willful misconduct.

Medical Consent in Emergencies

I authorize SFA staff to obtain emergency medical care on my own and/or

child's behalf if I am unable to provide consent due to injury or illness. I understand that I am financially responsible for any resulting medical care.

Acknowledgment and Consent

By signing below, I confirm that I have read, understand, and voluntarily agree to the terms outlined in this document, including informed consent for treatment and the voluntary activity liability waiver.

Client Name (Print): _____

Client Signature: _____ **Date:** _____

Legal Guardian Printed Name (If applicable): _____

Legal Guardian Signature: _____ **Date:** _____

Staff Name (Print): _____

Staff Signature: _____ **Date:** _____

This is the section for Releases of Information (ROIs).

*Please read the ROIs carefully and
make sure to write **clearly**.*

- We have included a blank ROI for the parent and/or legal guardian of the child; this is so that Set Free Alaska can schedule appointments and contact the individual who has legal guardianship of the child.
- We have also included an ROI for the Office of Children's Services as many of our referrals come from the Office of Children's Services.
- Please make a copy of a blank ROI if another agency needs to be aware of treatment, i.e., Guardian ad Litem.

**Please DO NOT put “X’s” on these forms as that is not allowable.
Please initial by what information you would like to disclose.**

*We have included an example on how to fill out all our ROIs.
We do not need these forms back.*

If any of these ROIs do not apply to you, please **do not** fill them out.



CONSENT FOR DISCLOSURE OF INFORMATION

I, Joey Smith DOB: 01/01/2021, REQUEST/AUTHORIZE **SET FREE ALASKA** AND
NAME OF ORGANIZATION AND INDIVIDUAL, OR THIRD PARTY PAYER: John Sinclair - Step-Father
MAILING ADDRESS: 1234 ABC Street Wasilla, AK 99654
PHONE: 907-123-4567 FAX: 907-123-8910 EMAIL: John@email.com

TO COMMUNICATE WITH AND DISCLOSE TO ONE ANOTHER THE FOLLOWING INFORMATION:

SPECIFIC INFORMATION TO BE RELEASED: (Guardians/minors over 10 yrs receiving SUD services)

JS

INITIAL FOR ALL LISTED BELOW OR: INITIAL ONLY WHAT APPLIES

☐ ASSESSMENT/INTERPRETIVE SUMMARY	☐ UA/DRUG TEST RESULTS
☐ TREATMENT PLAN	☐ ATTENDANCE
☐ TREATMENT REVIEWS/PROGRESS	☐ DISCHARGE SUMMARY
☐ PSYCHOLOGICAL EVALUATION	☐ FINANCIAL/PAYMENT INFORMATION
☐ VERBAL AND WRITTEN PROGRESS AND GENERAL COMPLIANCE	
☐ MEDICAL RECORDS	
☐ OTHER: _____	

FOR THE PURPOSE OF: (Guardians/minors over 10 yrs receiving SUD services)

JS

INITIAL FOR ALL LISTED BELOW OR: INITIAL ONLY WHAT APPLIES

☐ FURTHER TREATMENT/COORDINATION OF CARE	☐ FINANCIAL
☐ PAYMENT & HEALTH CARE OPERATIONS	
☐ LEGAL PURPOSES	☐ OTHER _____

INITIAL

JS

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug 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 the agencies identified above may not condition my treatment on whether I sign a consent form, but that in certain circumstances I may be denied treatment if I do not sign a consent form. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it.

THIS CONSENT AUTOMATICALLY EXPIRES ONE YEAR FROM LAST DATE OF SERVICE WITH SFA (or upon completion of financial obligation, whichever is later) UNLESS OTHERWISE SPECIFIED. OTHER DATE/EVENT: _____

I consent to my records to be released ☒ Electronically ☒ Hard Copy

SIGNATURE OF CLIENT (10YRS & ABOVE RECEIVING SUD SERVICES)

John Sinclair
SIGNATURE OF PARENT,
GUARDIAN OR REPRESENTATIVE

Mary Ashford
WITNESS SIGNATURE

PRINT NAME

Step-Father
RELATIONSHIP TO CLIENT

Mary Ashford
PRINTED NAME OF WITNESS

DATE

03/09/2026
DATE

03/09/2026
DATE

Recipients: If the information released pertains to drug and alcohol abuse, the confidentiality of the information is protected by federal law (CFR 42, Part 2) prohibiting you from making any further disclosures of this information without 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 information to criminally investigate or prosecute any alcohol or drug abuse patient.

THIS ROI IS REVOKED - CLIENT OR STAFF INITIAL, DATE AND TIME: _____



CONSENT FOR DISCLOSURE OF INFORMATION

I, _____ DOB: _____, REQUEST/AUTHORIZE SET FREE ALASKA AND
NAME OF ORGANIZATION AND INDIVIDUAL, OR THIRD PARTY PAYER: Office of Children's Services (OCS)
MAILING ADDRESS: 695 E Parks Highway, Unit 3 Wasilla, AK 99654
PHONE: 907-357-9797 FAX: _____ EMAIL: _____

TO COMMUNICATE WITH AND DISCLOSE TO ONE ANOTHER THE FOLLOWING INFORMATION:

SPECIFIC INFORMATION TO BE RELEASED: (Guardians/minors over 10 yrs receiving SUD services)

____ INITIAL FOR ALL LISTED BELOW OR: INITIAL ONLY WHAT APPLIES

____ ASSESSMENT/INTERPRETIVE SUMMARY	____ UA/DRUG TEST RESULTS
____ TREATMENT PLAN	____ ATTENDANCE
____ TREATMENT REVIEWS/PROGRESS	____ DISCHARGE SUMMARY
____ PSYCHOLOGICAL EVALUATION	____ FINANCIAL/PAYMENT INFORMATION
____ VERBAL AND WRITTEN PROGRESS AND GENERAL COMPLIANCE	
____ MEDICAL RECORDS	
____ OTHER: _____	

FOR THE PURPOSE OF: (Guardians/minors over 10 yrs receiving SUD services)

____ INITIAL FOR ALL LISTED BELOW OR: INITIAL ONLY WHAT APPLIES

____ FURTHER TREATMENT/COORDINATION OF CARE	____ FINANCIAL
____ PAYMENT & HEALTH CARE OPERATIONS	
____ LEGAL PURPOSES	____ OTHER _____

INITIAL

____ I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug 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 the agencies identified above may not condition my treatment on whether I sign a consent form, but that in certain circumstances I may be denied treatment if I do not sign a consent form. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it.

THIS CONSENT AUTOMATICALLY EXPIRES ONE YEAR FROM LAST DATE OF SERVICE WITH SFA (or upon completion of financial obligation, whichever is later) UNLESS OTHERWISE SPECIFIED. OTHER DATE/EVENT: _____

I consent to my records to be released ☒ Electronically ☒ Hard Copy

SIGNATURE OF CLIENT (10YRS & ABOVE
RECEIVING SUD SERVICES)

PRINT NAME

DATE

SIGNATURE OF PARENT,
GUARDIAN OR REPRESENTATIVE

RELATIONSHIP TO CLIENT

DATE

WITNESS SIGNATURE

PRINTED NAME OF WITNESS

DATE

Recipients: If the information released pertains to drug and alcohol abuse, the confidentiality of the information is protected by federal law (CFR 42, Part 2) prohibiting you from making any further disclosures of this information without 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 information to criminally investigate or prosecute any alcohol or drug abuse patient.

THIS ROI IS REVOKED - CLIENT OR STAFF INITIAL, DATE AND TIME: _____



CONSENT FOR DISCLOSURE OF INFORMATION

I, _____ DOB: _____, REQUEST/AUTHORIZE SET FREE ALASKA AND
NAME OF ORGANIZATION AND INDIVIDUAL, OR THIRD PARTY PAYER: _____

MAILING ADDRESS: _____

PHONE: _____ FAX: _____ EMAIL: _____

TO COMMUNICATE WITH AND DISCLOSE TO ONE ANOTHER THE FOLLOWING INFORMATION:

SPECIFIC INFORMATION TO BE RELEASED: (Guardians/minors over 10 yrs receiving SUD services)

____ INITIAL FOR ALL LISTED BELOW OR: INITIAL ONLY WHAT APPLIES

____ ASSESSMENT/INTERPRETIVE SUMMARY	____ UA/DRUG TEST RESULTS
____ TREATMENT PLAN	____ ATTENDANCE
____ TREATMENT REVIEWS/PROGRESS	____ DISCHARGE SUMMARY
____ PSYCHOLOGICAL EVALUATION	____ FINANCIAL/PAYMENT INFORMATION
____ VERBAL AND WRITTEN PROGRESS AND GENERAL COMPLIANCE	
____ MEDICAL RECORDS	
____ OTHER: _____	

FOR THE PURPOSE OF: (Guardians/minors over 10 yrs receiving SUD services)

____ INITIAL FOR ALL LISTED BELOW OR: INITIAL ONLY WHAT APPLIES

____ FURTHER TREATMENT/COORDINATION OF CARE	____ FINANCIAL
____ PAYMENT & HEALTH CARE OPERATIONS	
____ LEGAL PURPOSES	____ OTHER _____

INITIAL

____ I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug 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 the agencies identified above may not condition my treatment on whether I sign a consent form, but that in certain circumstances I may be denied treatment if I do not sign a consent form. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it.

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GUARDIAN OR REPRESENTATIVE

RELATIONSHIP TO CLIENT

DATE

WITNESS SIGNATURE

PRINTED NAME OF WITNESS

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THIS ROI IS REVOKED - CLIENT OR STAFF INITIAL, DATE AND TIME: _____

