JAMHI Health & Wellness, Inc.
An NCADD Affiliate

JAMHI Health & Wellness, Inc.

Salmon Creek Clinic	Midtown Clinic	JAMHI Family
3406 Glacier Hwy	1944 Allen Ct	8251B Glacier Hwy
Juneau, AK 99801	Juneau, AK 99801	Juneau, AK 99801
907-463-3303	907-463-6882	907-463-6877

AUTHORIZATION for RELEASE of PROTECTED HEALTH INFORMATION

I, _____ , Date of Birth: _____
Name of Client

hereby authorize **JAMHI Health & Wellness, Inc. (JAMHI)** to exchange information/document(s) with/

between the following agency or person: _____

ADDRESS: _____

PHONE # _____ FAX #: _____

INFORMATION TO BE RELEASED/RECEIVED: (Please check)

____ Behavioral Health / Substance Use Assessments	____ Medical Records	____ Other: _____
____ Psychiatric Assessments / Evaluations	____ Laboratory/Radiology	
____ Behavioral Health Treatment Plans	____ APA/Med 11/AD #2 Forms	
____ Medication List / Medication Management Notes	____ Billing Records	
____ Functional Assessments	____ Discharge Summary	
____ Redisclosure of third-party records on file at JAMHI for the purpose of payment, treatment and operations	____ Housing	
	____ Verification of Attendance	

PURPOSE OF INFORMATION: (Please check)

____ Legal Use	____ Benefits / Eligibility
____ Intake Information	____ Housing / Tenancy / Eligibility
____ Employment / Vocational Assistance	____ Personal / Self
____ Coordination of Treatment	____ Other _____

By signing this form I understand that:

* I am authorizing the use and disclosure of my healthcare and/or other information described above; my authorization is voluntary.
* I may revoke this authorization at any time by notifying the individuals(s) or organization releasing this information in writing or verbally, but if I do, it won't have any affect on actions taken on this authorization before my revocation was received.
* 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.
* The Protected Health Information (PHI) released may include information relating to communicable diseases including HIV/AIDS, and/or treatment for substance use disorders. _____ **I do not want this information to be disclosed.**
* 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.
* Requests for copies of medical records over ten (10) pages may be subject to copying fees.

DATE / EVENT:

This authorization expires on the following event: _____ or one (1) year from the date of signature if no other date or event is indicated.

_____ _____
Signature of Client Date

_____ _____
Signature of Witness (not required) Date

_____ _____
Signature of Authorized Representative (if required) AND Description of Representative's Authority Date

Recipient Information: If the information released pertains to alcohol or drug abuse, the confidentiality of the information is protected by federal law (42 CFR, 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 42 CFR, 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.