JAMHI Health & Wellness, Inc.

Salmon Creek Clinic
3406 Glacier Hwy
Juneau, AK 99801
(907) 463-3303

Jordan Creek Clinic
2075 Jordan Ave
Juneau Ak, 99801
(907) 463-6877

AUTHORIZATION for RELEASE of PROTECTED HEALTH INFORMATION

I, _____ (name of client), date of birth ____ / ____ / ____ (mm / dd / yyyy)
hereby authorize **JAMHI Health & Wellness, Inc.** to exchange information/document(s) with/between the following agency or person(s)

_____

ADDRESS _____

PHONE _____ FAX / EMAIL _____

INFORMATION TO BE RELEASED/RECEIVED (Please check)

_____ All categories of information listed below (if this is checked, categories of information below need not also be checked)

OR THESE SPECIFIC CATEGORIES

_____ Behavioral health / substance use assessments
_____ Psychiatric evaluations
_____ Treatment / safety plans
_____ Medication records
_____ Functional assessments
_____ Clinical progress notes
_____ Primary care records, including labs and radiology
_____ Billing records
_____ Housing
_____ Discharge summary
_____ Appointment information
_____ Other: _____

PURPOSE FOR RELEASE (Please check)

_____ Coordination of treatment
_____ Legal use
_____ Personal use
_____ Benefits / Support
_____ Housing / Tenancy / Eligibility
_____ 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 JAMHI Health & Wellness, Inc. in writing or verbally, except to the extent that action has been taken in reliance on it.
* 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 fees.

EXPIRATION

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

_____ Signature of Client or Legally Responsible Party

_____ Date

_____ Relationship to Client

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.