



**JAMHI Health & Wellness, Inc.**  
 Salmon Creek Clinic      Midtown Clinic  
 3406 Glacier Hwy      1944 Allen Court  
 Juneau Alaska 99801      Juneau, AK 99801  
 907-463-3303      907-463-6882

**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)**

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

**PURPOSE OF INFORMATION: (Please check)**

<input type="checkbox"/> Legal Use	<input type="checkbox"/> Benefits / Eligibility
<input type="checkbox"/> Intake Information	<input type="checkbox"/> Housing / Tenancy / Eligibility
<input type="checkbox"/> Employment / Vocational Assistance	<input type="checkbox"/> Personal / Self
<input type="checkbox"/> Coordination of Treatment	<input type="checkbox"/> 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 mental health care, communicable diseases, 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 Authorized Representative (if required)      Date  
 AND Description of Representative's Authority

\_\_\_\_\_  
 Signature of Witness (not required)      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.