Juneau Alliance for Mental Health, Inc.
3406 Glacier Hwy
Juneau Alaska 99801
907-463-3303

AUTHORIZATION for RELEASE of PROTECTED HEALTH INFORMATION

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

hereby authorize **Juneau Alliance for Mental Health, 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 Assessments / Addendums	____ Medical Records	____ Other: _____
____ Psychiatric Assessments / Evaluations	____ Laboratory/Radiology	
____ Behavioral Health Treatment Plans / Reviews	____ APA/Med 11/AD #2 Forms	
____ Medication List / Medication Management Notes	____ Billing Records	
____ Functional Assessments	____ Discharge Summary	
____ Substance Use Disorder Information	____ Housing	
____ Rediscloseure of third-party records on file at JAMHI for the purpose of payment, treatment and operations	____ Verification of Participation and/or Attendance	

PURPOSE OF INFORMATION: (Please check)

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

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 organziation 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 (or in the case of a criminal justice consent). 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.

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) AND Description of Representative's Authority Date

_____ _____
Signature of Witness 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.

Copy of this form given to Client: ☐ YES ☐ DECLINED