Juneau Youth Services

2075 Jordan Avenue
Juneau, AK 99801

Phone: 907.789.7610
Records Fax: 907.789.8401

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Including Substance Use Disorder Information

Please write legibly and complete this form in its entirety. Juneau Youth Services is unable to process incomplete or unsigned forms.

Client Name: _____ Date of Birth: _____

Client Mailing Address: _____

Primary Phone No.: _____

If the requested records consist of information from Family Therapy sessions, all individuals who participated in the Family Therapy must authorize the release of the information. See page 3.

RECIPIENT

I authorize Juneau Youth Services to use/disclose my health information, including my substance use disorder patient information, as described below:

a. Specific name of the person to whom the disclosure is to be made: _____

OR

b. Name of the entity to which disclosure is to be made, if the entity has a treating provider relationship with me (*for example, a hospital, clinic, etc.*), or the entity is a third-party payer (*for example, a health insurance company*):

_____

OR

c. If disclosure is to an entity without a treating provider relationship with me, the name of the entity that is authorized by me to receive my information (*for example: Smith Law Firm, LLC; Dept. of Juvenile Justice*):

_____

PERSON/ORGANIZATION RECIPIENT INFORMATION

_____ _____
Mailing Address E-mail Address

_____ _____ _____
City, State, ZIP Phone Fax

Method of transmission: ☐ Mail ☐ E-Mail (secure) ☐ Fax

USE OF INFORMATION

The information will be used/disclosed for the following purpose (be specific): _____

The receiving entity may also use this information as necessary for its own payment or health care operations activities.

AUTHORIZATION TYPE (COPIES OR VERBAL)

☐ I authorize JYS to disclose copies of my health records as described herein

☐ I authorize verbal discussion of my information as described herein.

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TYPE OF INFORMATION

I authorize disclosure of the following health and substance use disorder patient information (you may describe in detail how much and what type of information may be disclosed), including:

- ☐ Assessments
- ☐ Treatment Plans
- ☐ Psychiatric Assessments
- ☐ Pharmacological Management
- ☐ Discharge Summary
- ☐ Aftercare Plan
- ☐ Progress Notes (Client Only)
- ☐ Billing Records
- ☐ Payment and Claims Records
- ☐ Progress Notes (Family Therapy)

LENGTH OF AUTHORIZATION

Unless revoked, this authorization expires on the following date or event. If no end date/event is provided, this authorization will expire one (1) year after the signature date:

Expiring Date or Event: _____

APPLICABLE LAW

By signing this authorization form, I understand and agree that:

- My substance use disorder treatment information is protected under the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Recipients of my information pursuant to this authorization may not further disclose my substance use disorder information without my consent, unless specifically allowed under 42 C.F.R. Part 2 or HIPAA. Recipients will be notified of this obligation in the Prohibition on Re-Disclosure, which must accompany all disclosures of my substance use disorder information. 42 C.F.R. § 2.32.
- I may revoke this authorization in writing at any time by notifying Juneau Youth Services, except to the extent that Juneau Youth Services has already used or disclosed information in reliance on my authorization.
- I will not be denied services if I consent to disclosure, unless disclosure is necessary for Juneau Youth Services' proper treatment of me, obtaining payment for my services, or its health care operations.
- I have been given sufficient time to read, understand, and ask questions about this form.

SIGNATURE(S) – CLIENT RECORDS ONLY; NO FAMILY THERAPY INFORMATION

_____ _____
Signature of Client (*Including if Client is a Minor*) Date

_____ _____
Signature of Parent or Court-Appointed Legal Guardian Date
(*Where Required or Authorized to Consent Under 42 C.F.R. § 2.15*)

_____
Printed name of Parent or Legal Guardian (if applicable)

_____
Description of Legal Guardian's Authority (if applicable)

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SIGNATURE(S) – CLIENT RECORDS, WITH FAMILY THERAPY INFORMATION

Signature of Client (*Including if Client is a Minor*) | Date

Family Member #1 Printed Name

Family Member #1 Signature | Date

Family Member #2 Printed Name

Family Member #2 Signature | Date

Family Member #3 Printed Name

Family Member #3 Signature | Date

Family Member #4 Printed Name

Family Member #4 Signature | Date

If additional family members participated in the family therapy, provide their name, signature, and signature date on additional pages.

**Note: To sign for a patient, the guardian must be legally appointed by a court due to the patient's incompetency. 42 C.F.R. § 2.15(a). Power of attorneys and other types of guardians (like those appointed due to a patient's minority) are not authorized to sign on a patient's behalf. Updated as of 04.01.2021.*

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