Playful Journeys Counseling Center

634 S Bailey St. STE 201 • Palmer Alaska 99645 • Phone 907-290-3603 • Fax 907-931-6379

Authorization to Release Health Information (ROI)

Incomplete ROI's will not be processed.

Name of Patient information to be released | Patients Date of Birth

Name of Parent of Legal Guardian, if applicable (required for minors) | Patient Phone #/E-Mail (or legal representative, if applicable):

I authorize Playful Journeys to: ☐ Release Information To and/or ☐ Obtain Information From

Organization/Person: _____

Address: _____

City/State/Zip-Code: _____

Phone Number/Fax Number:

How would you like to receive these records? ☐ By fax ☐ By Mail ☐ Walk-In/Pickup ☐ By E-Mail

Description of Specific Information to be Disclosed: (Please check all that apply)

☐ Assessments	☐ Complete Health Record	☐ Discharge Summaries
☐ Education Records	☐ Medication Lists (if available)	☐ Pharmacological Management Notes
☐ Group Notes	☐ Therapy Notes	☐ Transfer Summaries
☐ Treatment Plans/Plan Reviews	☐ Written, Verbal, & Digital	☐ Other:

Service Date (From): _____ Service Date (To):_____ or Info. Pertaining To:_____

Specific Purpose of This Release of Information: (please check the best description):

☐ Coordination of Care ☐ Personal Use ☐ Legal Use ☐ Emergency Contact ☐ Billing/Referral

I understand that authorizing the disclosure of the above information is voluntary and I understand that the information in my health record may include records relating to sexually transmitted diseases, drug and/or alcohol abuse treatment, psychiatric and mental health care, or other sensitive information. I understand that if I am seeking behavioral health services, that the entity seeking this authorization will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign the authorization. I also understand that if I am seeking Drug and Alcohol Services subject to 42 C.F.R Part 2, that the entity seeking this authorization is not permitted to condition treatment, payment, enrollment or eligibility for benefits on the provision of a 42 C.F.R Part 2 compliant release for treatment purposes. I understand that I may request a copy of this authorization. I understand that a photocopy/fax of this authorization is as valid as the original. I understand that there may be a fee for copying associated with this request**.** *I understand that I have the right to revoke this authorization at any time except to the extent that information has already been released. Authorizations for the release of alcohol and drug abuse records protected by 42 C.F.R Part 2 can be revoked verbally. Authorizations covering all other health information must be revoked in writing.* I hereby authorize the use or disclosure of the health information as described above.

By signing this authorization, I authorize Playful Journeys Counseling Center to receive records from or disclose records to (as indicated above) certain protected health information *for the purpose of providing continued medical care for my or my child, at my request.* I understand that this information will be kept in my or my child's file. I understand my signature on this form is completely voluntary and is not a requirement for treatment in this clinic. I have had an opportunity to ask questions and my questions have been answered.

LEGAL NOTIFICATIONS

Minors only: *A minor patient's signature is required to release the following specific information:*
Conditions relating to productive care including, but not limited to, birth control and pregnancy related services and sexually transmitted diseases, including HIV/AIDS (pertains to minors age 14 or older). • Substance Abuse diagnosis or treatment and mental health conditions (age 13 and older).
I understand that this authorization expires one year from the date the form is signed, unless I submit a written request to the clinic prior to that date. I understand that a revocation is not effective to the extent that information has already been used or disclosed in reliance on this Authorization. I understand that information used or disclosed pursuant to this Authorization may be used or disclosed by the recipient and may no longer be protected by federal or state law.

Expiration Date or Event:_____ (Unless otherwise specified, this authorization will *expire one year from signature date***)**

_____ _____

Signature of Patient * Required for Patients over 18* | Signature Date

_____ _____

Signature of Parent/ Legal Representative if applicable *Required for minors* | Signature Date

_____ _____

Signature of Minor Patient *Required for Minors* | Signature Date