

# JMJ HealthCare Services, LLC

## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

**PLEASE READ FORM CAREFULLY AND FILL IT OUT COMPLETELY**

Mail  Pick-up  Fax

Client's Name: \_\_\_\_\_

DOB: \_\_\_\_\_

1. I Authorize:

2. To Release To:

JMJ Healthcare Services, LLC

\_\_\_\_\_  
Name of sending person/organization

\_\_\_\_\_  
Name of receiving person/organization

3327 Superior Lane #206

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Street Address

Bowie, Maryland 20715

\_\_\_\_\_  
City State Zip-Code

\_\_\_\_\_  
City State Zip-Code

240-206-8345

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Telephone Number

240-245-3064

\_\_\_\_\_  
Fax Number

\_\_\_\_\_  
Fax Number

*I freely give my consent to JMJ HealthCare Services, LLC and the addressee to exchange the information presented below. I understand that my/my child's records are protected under Federal Law Regulations and cannot be disclosed without my written consent unless otherwise permitted in accordance with Federal Law and Regulations. The purpose of this release is to provide continuity of care and to assist JMJ and the addressee in planning and providing services to me/my child. In no way will this information be used to discriminate against me/my child or deny me/my child services. This release shall remain in effect until the time I revoke this release or until one year after my/my child's last date of treatment. I may revoke or cancel this consent of release by notifying the Privacy Officer of JMJ HealthCare Services, LLC*

A Verbal exchange between JMJ HealthCare Services, LLC and addressee.

**Addressee to release**

- Demographic Information
- Intake Assessment
- Psychiatric Evaluation
- Medication Log
- Individual Treatment Plan
- Treatment Plan/ Reviews
- Transfer/Discharge Summary
- Other \_\_\_\_\_

**JMJ to release**

- Demographic Information
- Social Assessment/History
- Treatment Plan/Reviews
- Medication Record
- Individual Treatment Plan
- Transfer/Discharge Summary
- Aftercare Plan
- Other \_\_\_\_\_

Other Instructions/Notes: \_\_\_\_\_

\_\_\_\_\_  
Client Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
JMJ Healthcare Services, LLC Staff Signature

\_\_\_\_\_  
Date