

Patients can now complete and submit release electronically

Scan this QR code with the camera from your phone or tablet



### AUTHORIZATION FOR RELEASE OF INFORMATION – BEHAVIORAL HEALTH FACILITY

#### I. Patient Information

Full name of Patient:  
Address:  
Phone:

Date of Birth:  
Last four of SSN:

#### II. Disclosure

Information to be (select one):  sent to patient  sent to provider  hand carried (photo ID required)

I hereby authorize Health Information Management to disclose the following documentation (select all that apply):

- History and Physical
- Discharge Summary Plan
- Treatment Plan and Updates
- Lab Information
- Evaluation(s)
- Discharge Summary
- Abstract Summary
- Drug/Breathalyzer Screening Results
- Progress Note Summary
- Intake Assessment
- Medication Information
- Summary Letter

Other: \_\_\_\_\_

To: \_\_\_\_\_  
(Name of Facility/Provider and complete mailing address and phone number)

For the purpose of: \_\_\_\_\_

For the period of time from \_\_\_\_\_ to \_\_\_\_\_

I understand that this authorization extends to all or any part of the records/information designated above, which may include treatment for physical and mental illness, alcohol/drug abuse, HIV/AIDS test results or diagnosis.

I understand the nature of this Release and freely give(s) consent

Patient Signature (age 13 and up): \_\_\_\_\_ Date: \_\_\_\_\_  
Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**REVOCATION:** I have the right to stop this release of information at any time. I understand that I cannot do anything about information already disclosed under this Authorization. Revocation must be submitted in writing, signed, dated, and handed to the Release of Information Technician. My decision to revoke the authorization may result in my insurance company not being able to pay for the medical care, and I may be liable for payment of the claims. I understand that this facility cannot require me to sign this authorization in order to receive treatment.

**EXPIRATION:** Unless revoked earlier, this Authorization expires 90 days from the date of my signature.

**TO THE PARTY RECEIVING THIS INFORMATION:** This information has been disclosed to you from the records whose confidentiality may be protected by 42 C.F.R. Part 2. These federal regulations prohibit you from making any further disclosure without specific written consent of the person to whom these medical records pertain, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information 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.