BHR
Behavioral Health Response

Client Request for Release of Protected Healthcare Information

I am completing this form to allow the use and sharing of protected healthcare information about:

Printed name: _____ Date of birth: _____ SSN_____

I authorize Behavioral Health Response (BHR), 12647 Olive Blvd. Ste. 200, St. Louis, MO 63141 to use or disclose the following information. **Please initial area(s) of authorization:**

_____ Records of telephone contacts including assessment of and recommendations for psychiatric, psychological, emotional and alcohol or drug use or abuse issues.
_____ Records of outreach evaluations including assessment of and recommendations for psychiatric, psychological, emotional and alcohol or drug use or abuse issues.

Date(s) of service included under this authorization are: _____ through _____

I authorize disclosure to:_____

_____

For the purpose of: _____

_____

I understand that this authorization will expire on (DD/MM/YR): _____

I understand that I can revoke (cancel) this authorization by sending a written request to BHR. If I do so, I understand that it will prevent disclosure after the date the request is received but cannot change the fact that information may have been disclosed before that date.

I understand that I may inspect and receive a copy of the health information described on this form. I understand that I may receive a copy of this form.

I understand that if the person or organization that receives the information is not a healthcare provider or healthplan, the disclosed information may no longer be protected by federal privacy regulations.

_____ _____
Signature of client or personal representative Date

_____ _____
Printed name of client or personal representative Relationship to the client

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Fax: Release to 314-469-0412
Or mail to 12647 Olive Suite 200, St. Louis MO 63141
Email is not HIPAA compliant