RELEASE OF INFORMATION

BHR Case Number:_____

Authorization for Use or Disclosure 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: _____

I authorize Behavioral Health Response (BHR), 5501 Delmar Blvd Suite B300, St. Louis MO 63112 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.
_____ Other: _____
_____
_____

Date(s) of service included under this authorization are: _____/_____/_____ through _____/_____/_____
(MM DD YY) (MM DD YY)

I authorize disclosure to:
Name:_____

Phone:_(_____)_____
Fax:
_____
Address:
_____
Email
Address:_____

Send by Secure Fax Mail Encrypted Email Unencrypted Email

For the purpose of: Clinical Records
Other: _____

_____

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

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 there may be a cost for preparing and releasing records.

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.

_____ _____

RELEASE OF INFORMATION

BHR Case Number:_____

Signature of Client or Personal Representative	Date
Printed Name of Client or Personal Representative	Relationship to Client
Signature of Professional or Witness	Date

_____ By initialing here I acknowledge that I received a copy of this completed form.

Reports will only be sent once reviewed by designated BHR staff and to a secure location only.