



RELEASE OF INFORMATION

BHR Case Number: Click or tap here to enter text.

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: Click or tap here to enter text.

Date of birth: Click or tap here to enter text.

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:**

Click or tap here to enter text. Records of telephone contacts including assessment of and recommendations for psychiatric, psychological, emotional and alcohol or drug use or abuse issues.

Click or tap here to enter text. Records of outreach evaluations including assessment of and recommendations for psychiatric, psychological, emotional and alcohol or drug use or abuse issues.

Click or tap here to enter text. Other: Click or tap here to enter text.

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

I authorize disclosure to:

Name: Click or tap here to enter text.

Phone: Click or tap here to enter text.

Fax: Click or tap here to enter text.

Email: Click or tap here to enter text.

Address: Click or tap here to enter text.

Send by: Secure Fax Mail Encrypted Email Unencrypted Email

For the purpose of: ☐ Clinical Records

☐ Other: Click or tap here to enter text.

I understand that this authorization will expire on: ____/____/____

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: Click or tap here to enter text.

Click or tap here to enter text.

Signature of Client or Personal Representative

Click or tap to enter a date.

Date

Click or tap here to enter text.

Printed Name of Client or Personal Representative

Click or tap here to enter text.

Relationship to Client

Click or tap here to enter text.

Signature of Professional or Witness

Click or tap to enter a date.

Date

Click or tap here to enter text. 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.