# 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), 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.
_____ Presence during outreach, coordination of care and ongoing follow up
_____ Other: _____
_____

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

I authorize disclosure to: Name: _____
Email: _____
Phone: (_____) _____
Fax: _____
Address: _____

Send by ☐ Secure Fax ☐ Mail ☐ Encrypted Email ☐ Unencrypted email (phone number required to discuss risks)

For the purpose of:
☐ Clinical Records
☐ Coordination of Care
☐ 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.

_____ _____
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.***