BURRELL BEHAVIORAL HEALTH

MRN: _____ DOB: _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

1. CLIENT/PATIENT INFORMATION

Legal Name (First, Middle, Last): _____ Date of Birth (mm-dd-yyyy): _____

List any aliases or previous names you have used: _____

Address (Street, City, State, Zip Code): _____

Email (unless otherwise specified, records will be delivered via secure email): _____

2. RELEASE PURPOSE

☐Personal ☐Legal ☐Continuity of Care ☐Other (specify): _____

3. WHO DO YOU WANT TO RELEASE YOUR INFORMATION? (select only one)

☐ Burrell Behavioral Health & affiliates

☐Other (specify): Name: _____ Phone: _____

Address: _____ Fax: _____

4. WHO DO YOU WANT YOUR INFORMATION GIVEN TO? (select only one)

☐Myself (client/patient) ☐Legal Guardian ☐Legal Representative

☐Other (specify): Name: _____ Phone _____

Address _____ Fax _____

5. DELIVERY METHOD

☐US Mail (address): _____

☐Secure Email Address: _____ ☐FAX Number: _____

☐Pick up at location (specify): _____

☐Other: _____

6. EXPIRATION

Unless otherwise revoked, this authorization will expire 1 (one) year from the date signed or on:

ATTN: ILLINOIS residents are required to enter an expiration date.

☐Expiration Date: _____ or ☐Expiration Event: _____

7. TIMEFRAME AND TYPE OF RECORDS TO BE RELEASED

Timeframe (select one) ☐All records within these dates of service (mm-dd-yyyy) _____ to _____

☐All past, present, and future records

Type of Records:

☐Treatment/Service Dates
☐Psychological Evaluations
☐Metabolic/Health Screening
☐Progress Toward Goals
☐Other (specify): _____

☐Complete Record
☐Lab Results
☐Assessments
☐Progress Notes
☐Crisis/Safety Plan

☐Medication List
☐Treatment Plans
☐Imaging Reports
☐Discharge Summary
☐Diagnoses

☐Immunizations
☐Housing
☐Employment
☐Reports (Court/School/ Probation)

☐I authorize the release of any of the above marked records that contain information related to alcohol/substance use including urine drug screenings/drug test results/non-compliance with treatment.

☐I authorize the release of any of the above marked records which may indicate the presence of communicable, non-communicable, or venereal diseases including but not limited to HIV/AIDS.

Note: This is a 2-page form and is not valid without both pages.

8. SIGNATURE AND DATE: Please read the following statements carefully before signing this form.

This authorization may be revoked at any time, except to the extent that the agency has taken reliance on it, by executing an electronic written revocation, or by providing written notice of revocation to: Health Information Department, 1111 S. Glenstone Ave., Springfield, MO 65804.Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law. 42 CFR Part 2 prohibits the unauthorized re-disclosure of alcohol/substance use disorder treatment records. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether or not you sign this authorization. You may request a copy of this signed authorization & you have the right to inspect and receive a copy of the material to be disclosed. We may charge for copies of records in accordance with state law. Note: A patient/client (18 years or older) must authorize the release of their own records unless incapacitated or deceased. If signing for a minor, I hereby state that my parental rights have not been revoked by a court of law. Specific situations may require minor's authorization. **Signature dates are required (mm/dd/yyyy).**

Client/Patient Signature: _____	Date: _____
Legal Gdn./Rep.Signature: _____	Date: _____
Printed Name: _____	Relationship to Client/Patient ☐Parent ☐Legal Guardian ☐Legal Authorized Rep.
ILLINOIS Only Witness Signature: _____	Date: _____
☐ Check this box if client/patient is deceased.	

IMPORTANT: Any authorization with alterations must have the alterations initialed by the client or guardian. Alterations that are not initialed will be invalid.

INSTRUCTIONS: When picking up copies in person, a photo ID will be required as well as a copy of any legal documentation verifying legal right to request such information.

Section 1: Type or write client/patient name, including any aliases or previous names used, date of birth and address. Check box if client/patient is deceased.

Section 2: Indicate the reason information is being requested. For client/patient access to your own records, check personal.

Section 3: Indicate who you are requesting information FROM.

Section 4: Indicate who you want the information released TO. If the client/patient is a minor, list Legal Guardian's name and address. Only one option can be selected.

Section 5: Indicate how you want the information to be delivered to the recipient.

Section 6: Provide an expiration date or event upon which the authorization will expire. An event may include things such as, 60-past discharge from all services, 30-days past release of probation, etc. If no date/event is provided the authorization will expire 1 (one) year from the date it is signed.

Section 7: Enter the date range of records you are requesting. If you wish to release a series of visits extending into the future, you may mark the box for the option of "past, present, and future." Mark the type of records requested. If "Complete Record" is selected the following shall be produced for the designated time period if present in the record: History and Physical examinations and reports; medication list, preadmission screening, progress notes, treatment plan and treatment plan updates, prescriptions and Physician orders, Vital Signs, Transitions/aftercare plan, Discharge Summary, Case management records, Referrals, Comprehensive Assessment and Psychiatric Evaluation, Diagnostic Tests and Lab results. You may limit the amount of information provided by only checking the corresponding boxes of the information needed or specifically specifying in the "Other" box. Records related to alcohol or substance use disorder treatment, HIV/AIDS, and/or communicable disease must be specifically authorized. Mark these boxes if your desire is to authorize the release of these records/information.

Section 8: Read disclosures, sign and date authorization. If signed by someone other than the client/patient, include legal documentation, print full name and indicate relationship to client/patient. Specific situations may require a minor's authorization. Illinois residents must obtain a witness signature.

Please contact ROI/Medical Records at the address/phone number listed below if you have questions.

833-763-0418 | Fax: 660-677-4005 | ROI@burrellcenter.com

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