BURRELL®
BEHAVIORAL HEALTH

Receiving staff complete this section:

Medical Record Number	Client Name
Date/Time Received	Staff Name
Route completed form to ROI.	

064

Authorization to Release Protected Health Information

(Instructions on Page 2)

1. CLIENT INFORMATION

Client Name *(First, Middle, Last)* | Date of Birth *(mm-dd-yyyy)* | ☐ Check this box if client is deceased.

Client Address *(Street, City, State, ZIP Code)*

2. RELEASE PURPOSE

☐ Personal ☐ Legal ☐ Continuity of Care ☐ Other:

3. WHO DO YOU WANT TO RELEASE YOUR INFORMATION?

Check one box and complete if applicable.

☐ **Burrell Behavioral Health and its affiliates**

☐ **Other,** specify organization, department, or individual

_____

Street _____

City _____

State _____ ZIP Code _____

Phone _____ Fax _____

4. WHO DO YOU WANT YOUR INFORMATION GIVEN TO?

Check one box and complete if applicable.

☐ **Myself**

☐ **Legal Guardian** _____

☐ **Other,** specify organization, department, or individual

_____

Street _____

City _____

State _____ ZIP Code _____

Phone _____ Fax _____

Unless otherwise revoked, this authorization will expire on the following date: _____
If left blank, this authorization will expire 1 year from the date signed.

5. DELIVERY OF INFORMATION

☐ US Mail (address listed above)
☐ FAX (number listed above)
☐ Electronic via secure email (list email address)_____
☐ Pick-up at a Burrell location (please specify location) _____
☐ Other, specify_____

6. RECORDS TO BE RELEASED

Timeframe to Be Released

FROM _____ *(mm-dd-yyyy)* TO _____ *(mm-dd-yyyy)*

Type of Records (check all that apply)

☐ Complete Record ☐ Treatment Plans ☐ Billing Information ☐ Medication List
☐ Assessments ☐ Diagnoses ☐ Appointment Dates/Times ☐ Discharge Summary
☐ Progress notes ☐ Lab Results ☐ Psychological Evaluations ☐ Other: _____

Substance Use Disorder Treatment (SUD) Records (check all that apply)

☐ Complete Record ☐ Treatment Progress ☐ Treatment Outcome
☐ SUD Assessments ☐ Lab Results/SUD Screen Results ☐ Compliance/Non-compliance with Treatment
☐ Aftercare Plans ☐ SUD Medications ☐ Discharge Summary

Other, specify if applicable _____

BURRELL®
BEHAVIORAL HEALTH

Client Name *(First, Middle, Last)*
Date of birth *(mm-dd-yyyy)*
Medical Record Number

064

Authorization to Release Protected Health Information

7. SIGNATURE AND DATE *The client or legal representative must sign and date this authorization.*

- This authorization may be revoked at any time by providing a written notice of revocation to the Release of Information (ROI) dept. at 1300 E. Bradford Parkway, Springfield, MO 65804, except to the extent that the agency has already taken action in reliance on it.
- I understand the information to be released includes behavioral and/or mental health care records and could include records related to HIV/AIDS, communicable diseases and/or treatment for alcohol or substance use disorder.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Law.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether or not I sign this authorization.
- I may request a copy of the signed authorization.
- I may be charged for copies in accordance with state law.
- I have a right to inspect and receive a copy of the material to be disclosed.
- Federal law /42 CFR Part 2 prohibits unauthorized disclosure of these records.

Note: A client (18 years or older) must authorize the release of their own information unless incapacitated or deceased. If signing for a minor client, I hereby state that my parental rights have not been revoked by a court of law. Specific situation(s) may require minor's authorization.

Signature (required) ▶	**Date** (required) *(mm-dd-yyyy)*

Printed Name of Person Signing **(if not client)** *(First, Middle, Last)*

Relationship to Client

☐ Biological/Adoptive Parent ☐ Legal Guardian ☐ Legal Authorized Representative

NOTE: If signed by a patient's authorized representative, supporting legal documentation must accompany this authorization form.

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.

1. Section 1: Type or write client name, date of birth and address. Check box if client is deceased.
2. Section 2: Indicate the reason information is being requested. For client access to your own records, check personal.
3. Section 3: Indicate who you are requesting information **FROM**.
4. Section 4: Indicate who you want the information released **TO**. If the client is a minor, list Legal Guardian's name and address.
5. Expiration date: Provide an expiration date. If no date is provided the authorization will expire 1 (one) year from the date it is signed.
6. Section 5: Indicate how you want to receive the information.
7. Section 6:
    a. Enter the date range of records you are requesting. If you do not know the exact dates the month and year will be accepted. (Example: May 2002 - September 2003). If you wish to release a series of visits extending into the future, you may enter the option of "past, present, and future."
    b. Enter the type of records requested. You may limit the amount of information provided by only checking the corresponding boxes of the information needed. Substance Use Disorder records require special protections and are listed separately.
8. Section 7: Read disclosures, sign and date authorization. If signed by someone other than the client, include legal documentation, print full name and indicate relationship to client.
9. Please contact the ROI department at the address or phone number listed below if you have questions or concerns. Due to the high volume of phone calls, please allow 1-2 business days for a response. We appreciate your patience and look forward to serving you.

Burrell Behavioral Health - Release of Information Department
1300 E. Bradford Parkway Springfield, MO 65804 | Phone: (417) 761-5270 | FAX: (229) 516-8290| ROI@burrellcenter.com

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