BLUE RIDGE BEHAVIORAL HEALTH
170 Thomas Johnson Drive, Suite 200, Frederick, MD 21702
Phone: 301-695-8390 / Facsimile: 301-694-7906

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION – For Purposes of Billing/Payment Collections Only

Information Release for: _____ _____
Printed Name of Patient Patient's Date of Birth

I hereby authorize Blue Ridge Behavioral Health (BRBH) to communicate with the individual(s) listed below only for purposes of: 1) collecting payment due on my account(s) at BRBH and 2) answering questions specific to billing and payment collections pertaining to my account(s).

Authorized communication can include only the following information: date and time (if applicable) of any provided services including missed appointments; type and level of services; name of BRBH clinician(s); and fees due or paid for any rendered services or missed appointments, which include appointments that are cancelled or rescheduled with less than 24 business hours' notice excluding weekends and holidays.

This authorization does not apply to issues beyond those noted above. This authorization is specific to this request only and is not a universal authorization.

I understand that once information is disclosed in accordance with this authorization, it may be redisclosed by the recipient(s) and no longer protected by HIPAA Privacy Rules. I further understand that Blue Ridge Behavioral Health does not have any ability to prevent subsequent disclosures of my information by the recipient(s).

I authorize communication, restricted to the purposes and information as stated above, with the following:

Name: _____ Relationship to Patient: _____

Phone Number(s): _____ / _____

Mailing Address: _____

Name: _____ Relationship to Patient: _____

Phone Number(s): _____ / _____

Mailing Address: _____

This authorization to disclose may be revoked by me at any time except to the extent that Blue Ridge Behavioral Health has already disclosed information by having acted on my prior consent.

I understand that I may cancel this authorization at any time by providing Blue Ridge Behavioral Health with written communication that includes the date that my authorization is withdrawn.

This authorization is valid for one year from the date signed below or until _____.

_____ _____
Printed Name of Patient **Date**

_____ _____
Signature of Patient **Date**