# BLUE RIDGE BEHAVIORAL HEALTH

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## AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

**This authorization form is required for disclosure of all medical and/or psychotherapy notes.**

Information Release for: ______________________________ ______________________________

Patient Name (Please Print) Patient Date of Birth

I hereby authorize ____________________________________________________________ to

(Blue Ridge Clinician)

☐ release to: ☐ obtain from: ☐ exchange with:

Name: ______________________________

Address : ______________________________

City, State, Zip: ______________________________

Phone: ______________ Fax: ______________

The following information:

- ☐ complete medical record
- ☐ psychotherapy notes
- ☐ lab reports
- ☐ consultation reports
- ☐ medications
- ☐ substance abuse treatment
- ☐ other: ______________________

The purpose for this disclosure is: ______________________________________________

Only the minimum information necessary for the appropriate evaluation and treatment of the patient will be released. 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 BRBH does not have any ability to prevent subsequent disclosures of my information by the recipient(s).

This authorization is specific for this request only and is not a universal authorization. Future requests for disclosure of medical information will require a new and specific authorization.

This authorization goes beyond the consent for Release of Information for purposes of payment, treatment, and Health Care Operations. I understand that I do not have to sign this authorization in order to receive health care benefits.

**THIS AUTHORIZATION TO DISCLOSE MAY BE REVOKED BY ME AT ANY TIME EXCEPT TO THE EXTENT THAT INFORMATION HAS ALREADY BEEN RELEASED.** Please notify us in writing if you want to revoke this authorization.

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

______________________________ ______________________________

**Signature of Patient/Parent/Guardian** **Date Signed**

______________________________

**Print Name if not Patient**

______________________________ ______________________________

**Signature of Witness/Title** **Date Signed**