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: ____________________________________   __________________________
Patient Name (please print)   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 on said account(s).

Authorized communication can include ***only*** the following information: date/time (if applicable) of any provided services (or no-shows/late cancellations); type/level of services; name of Blue Ridge provider(s); and fees due or paid for any rendered services, missed appointments, or cancelled appointments with less than 24 (business) hours' notice.

This authorization DOES NOT apply to issues beyond those noted above. This authorization is specific for 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 BRBH 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 BRBH HAS ALREADY DISCLOSED INFORMATION BY HAVING ACTED ON MY PRIOR CONSENT.

I understand I may cancel this authorization at any time by providing to the Office of Blue Ridge Behavioral Health written communication that includes the date this authorization will end.

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

____   _________________________
Signature of Patient   Date Signed