BLUE RIDGE BEHAVIORAL HEALTH SERVICES

170 Thomas Johnson Drive, Suite 200, Frederick, MD 21702
Phone: 301-695-8390 Facsimile: 301-694-7906

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 ☐ consultation reports ☐ other: _____
☐ psychotherapy notes ☐ medications
☐ lab reports ☐ substance abuse treatment

The purpose for this disclosure is: _____

I understand that all information released will be handled confidentially. This authorization is specific for this request only and is not a universal authorization. Only the minimum information necessary for the appropriate evaluation and treatment of the patient will be released.

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**