Blomquist Hale
SOLUTIONS

Authorization to Release Information

Name of Client: _____ **Date of Birth:** _____

Clinician Name: _____ **Dates of Treatment:** _____

Purpose of Release of Information: _____

Names of Persons and Organizations Authorized to Receive Information:

_____

A Description of the Information or Records and dates authorized to be disclosed:

_____

I authorize and consent *to the disclosure of any information or records related to issues of my condition, care and treatment to the above-named person(s) or organization(s).*
I understand *that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule. I therefore release BHC from any liability relating to disclosures hereby authorized.*
I understand *that I have the right to inspect and copy the written information to be disclosed.*
I understand *that if I do not consent to this authorization, the information sought to be disclosed will not be disclosed except as provided by law. I further understand that BHC may not condition services upon my signing an authorization.*
This authorization *is valid until a satisfactory resolution of the problem is complete and issues pertaining there-to are fully addressed. This consent may be revoked in writing at any time. Such revocation will have no effect on disclosures previously made in reliance on this authorization.*

Date: _____ **Expiration Date or Event:** _____

Signature: _____

If Parent or Guardian, please specify relationship: _____

Witness: _____

Where would you like the records sent? (Choose one)

Fax: _____

Email: _____

Address: _____