

# Bear River Mental Health Services, Inc.

90 East 200 North, Logan, Utah 84321 – 663 West 950 South, Brigham City, Utah 84302 –  
18 North 200 East, Suite 403, Tremonton, Utah 84337

## AUTHORIZATION FOR DISCLOSURE OF INFORMATION

Name (please print): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

In authorizing this disclosure I understand that:

- I do not have to sign this form in order to get treatment; and
- The information released may be subject to re-disclosure and no longer protected by the Federal Privacy Rule.

**I AUTHORIZE BEAR RIVER MENTAL HEALTH TO DISCLOSE AND/OR RECEIVE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION (PHI) TO AND/OR FROM:**

Name of person or party: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### SPECIFIC INFORMATION AUTHORIZED FOR DISCLOSURE:

\_\_\_ Medical/Physical History \_\_\_ Medication Records \_\_\_ Psycho/Social History \_\_\_ Consultation Reports

\_\_\_ Psychological Test Reports \_\_\_ Admission Assessment \_\_\_ Treatment Plan \_\_\_ Progress Notes

\_\_\_ Other (please specify) \_\_\_\_\_

**DATE(S) OF TREATMENT RELATED TO DISCLOSURE** (if applicable): \_\_\_\_\_

**PURPOSE OF DISCLOSURE:** \_\_\_\_\_

**EXPIRATION DATE/EVENT:** This authorization is good for **365 days**, or \_\_\_\_\_ days from the date the client or the client's personal representative (if applicable) signs this form. This authorization may be revoked at any time in writing before the date it ends, except as far as any action based on this authorization has already been taken.

\_\_\_\_\_  
Client Signature Phone # Date

\_\_\_\_\_  
Signature of Parent, Guardian, or other Personal Representative Date

\_\_\_\_\_  
Personal Representative's legal relationship to the client

\_\_\_\_\_  
I.D. Verification/Witness

Unless otherwise permitted or required by law, it is the policy of BRMH to limit disclosures of Protected Health Information to the minimum necessary to accomplish the intended purpose of the disclosure.