Bear River Mental Health Services, Inc.

90 East 200 North, Logan, Utah 84321 (435-752-0750) ● 663 West 950 South, Brigham City, Utah 84302 (435-734-9449)
440 West 600 North Tremonton, Utah 84337 (435-257-2168)

AUTHORIZATION FOR RELEASE OF RECORDS and/or REQUEST FOR ACCESS

Name: _____ Date of Birth: _____
(person whose information is to be released)

☐ I am requesting **ACCESS** (For Myself) to Protected Health Information (PHI)

Process may be denied: We may deny access to information complied in anticipation of, or for use in a civil, criminal, or administrative proceeding, or if the information was received by someone other than a health care provider under a promise of confidentiality, or if we believe it is reasonably likely to endanger you or someone else.

- You have a right to make a written request to inspect/obtain a copy of PHI about yourself.
- You have a right to have an answer to your request for access in writing within 30 days.

FORMAT YOU WANT THE PHI PROVIDED IN: ☐ Hard Copy ($.50 per page) ☐ Electronic Copy ($20.00 CD) ☐ Summary ($.50 per page)

☐ I am authorizing **DISCLOSURE** (To Another Party) of Protected Health Information (PHI)

In authorizing disclosure I understand that:

- I do not have to disclose protected health information in order to get treatment; and
- The PHI we release may be re-released by the recipient and no longer protected by the Federal Privacy Rule.

IN REGARDS TO MY PHI, I HEREBY AUTHORIZE BEAR RIVER MENTAL HEALTH SERVICES, INC. TO RELEASE, RECEIVE, OBTAIN, AND PROVIDE INFORMATION TO/FROM:

PERSON OR AGENCY PHI IS BEING RELEASED TO: ☐ Send Information to ☐ Receive Information from ☐ File only

Name: _____ Relation: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

SPECIFIC INFORMATION TO BE ACCESSED\DISCLOSED:

☐ Medical/Physical History ☐ Psychological Testing Reports ☐ Care Plan

☐ Medication Notes/Logs ☐ Admission Assessment ☐ Progress Notes

☐ Consultation Reports ☐ Encounters ☐ Verbal Disclosure

☐ Entire Clinical Record ☐ Other (specify): _____

DATE(S) OF TREATMENT RELATED TO RECORDS REQUESTED/RELEASED: (if applicable) _____

PURPOSE OF DISCLOSURE (***Required***): ☐ Coordination of care ☐ Legal ☐ At the request of the individual

☐ Benefits Determination ☐ Other (specify): _____

EXPIRATION DATE/EVENT: This authorization is valid for **365 days**, or _____ days from the date of the client's signature, or signature of the client's personal representative if applicable. This authorization may be revoked at any time in writing and by submission to BRMH prior to the expiration date, except to the extent that action based on this authorization has already been taken.

Client Signature _____ Phone # _____ Date _____

Personal Representative Signature _____ Print Name _____ Relationship to Client _____ Date _____
(If client is a minor or incapacitated)

Facilitator and witness to this form: _____

Parent – *If parent is divorced or Custody Order is in place, parent must have legal custody of the minor and verification provided by a Court Order.*
Legal Guardian - *Guardianship must be verified by a Court Order.*
Foster Parent - *Foster Parent does not have legal custody and is, therefore, NOT a personal representative.*

Unless otherwise permitted or required by law, it is the policy of BEAR RIVER MENTAL HEALTH to limit the disclosure of PHI to the minimum necessary to accomplish the intended purpose of the disclosure.