Bear River Mental Health Services, Inc.

90 E 200 N, Logan, UT 84321 (435-752-0750) ● 663 W 950 S, Brigham City, UT 84302 (435-734-9449) ● 440 W 600 N Tremonton, UT 84337 (435-257-2168)

AUTHORIZATION FOR RELEASE OF RECORDS and/or REQUEST FOR ACCESS

NOTE: **Under the HIPAA Privacy Rule, BRMH has up to 30 calendar days after receipt of the request to process an individual's request for records.**

Name: ____________________________ Date of Birth: ______________ Client Phone: _________________
(person whose information is to be released)

❖ STEP 1

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

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.

AND/OR

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

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.

☐ Verbal Disclosure ☐ Send Information To ☐ Request Information From **(check all that apply)**

PERSON OR AGENCY PROTECTED HEALTH INFORMATION IS BEING RELEASED TO or REQUESTED FROM:

Name:____Relation:______________________

Address:____

City:___________________________________State:________________Zip: ______________

Phone Number: ____________________________Fax Number: ____________________________

PURPOSE OF DISCLOSURE (*Required*): ☐ Coordination of Care ☐ Legal ☐ At the request of the individual ☐ Benefits Determination ☐ Other (specify): _______________

❖ STEP 2 (this section is not applicable to Verbal Disclosure) Information will not be released via email.

HOW DO YOU WANT TO RECEIVE RECORDS? ☐ **Paper Copy** ☐ **Thumb Drive (additional $4)** ☐ **Fax** ☐ **Postal Mail OR** ☐ **Pick Up**

SPECIFY INFORMATION TO BE RELEASED BELOW:

★☐ **FREE PACKAGE:** current assessment, current care plan, last 3 months of service notes, last 6 months of medication logs; otherwise, cost is $.50 per page, with a maximum of $20 for Medicaid enrollees.

OR

☐ Therapist Summary Letter ☐ Assessment ☐ Care Plan ☐ Service Notes ☐ Encounters
☐ Psychological Testing ☐ Medical/Medication Notes/Logs ☐ Other (specify) ____________________________

INDICATE DATE(S) OF TREATMENT RELATED TO RECORDS BEING RELEASED: ____________________________

❖ STEP 3

EXPIRATION DATE: This authorization is valid until client's termination of enrollment in the health plan or until the client/guardian chooses to revoke this authorization in writing to Bear River Mental Health Services, Inc. using the Revocation of Authorization form, whichever occurs first, except to the extent that action based on this authorization has already been taken.

______________________________ ______________________
Client Signature Date

______________________________ ______________________ ____________________ ___________
Personal Representative Signature*(if client is a minor or incapacitated)* Print Name Relationship to Client Date

BRMH staff accepting this ROI (please PRINT NAME) ______________________________

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.