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: **The HIPAA Privacy Rule allows BRMH up to 30 calendar days after receipt of this request to process request for records.**

Name: ______________________________________ Date of Birth: ________________ Client Phone: ___________________
(person whose information is to be released)

❖ STEP 1

☐ I am requesting **COPIES** of my records

We may deny this request 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.

AND/OR

☐ I am giving **PERMISSION** for another party to receive my information

I understand that I do not have to disclose my records in order to get treatment, and my records 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)**

RECORDS ARE BEING GIVEN TO: ☐ PERSON ☐ AGENCY ☐ SCHOOL

Name: ____Relation:_________________________

If School: ☐ Administration ☐ School Counselor ☐ Instructor ☐ Behaviorist ☐ Other __________________

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 YOUR RECORDS WILL BE PREPARED? ☐ **Paper Copy** ☐ **Thumb Drive (additional $4)** ☐ **Fax** ☐ **Postal Mail OR** ☐ **Pick Up**

RECORDS TO BE RELEASED:

★☐ **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) ________________________________

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

____ ___________________________ ______________________ ____________
Legal Guardian 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 legal guardian.*