Beacon Mental Health
3100 NE 83rd, Kansas City, MO 64119 (816) 468-0400

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Client Name: _____	**Person making request:** _____
DOB: _____	**Relationship:** _____

Authorization: ☐ Disclose to ☐ Receive from ☐ Both Disclose to & Receive from

Name of Individual/Agency: _____
Address (street, city, zip) of Individual/Agency: PLEASE INCLUDE FULL ADDRESS & ZIP CODE:
_____
Phone # of Individual/Agency: _____
Fax # of Individual/Agency: _____ *Fax authorized? YES* ☐ *NO* ☐

This information is requested for the PURPOSE of:	***The MINIMUM NECESSARY for WRITTEN requests information to accomplish the purpose is:***	***The MINIMUM NECESSARY for VERBAL requests information to accomplish the purpose is:***
☐ Continuity of Care ☐ Application/reapplication for benefits ☐ Disability determination ☐ Legal Proceedings ☐ Spenddown ☐ Client Request ☐ Other (specify): _____	☐ Medications ☐ Treatment Plans ☐ Assessments ☐ Progress Notes ☐ Referrals ☐ Lab ☐ Discharge Summary ☐ Financial Information ☐ Form completion ☐ Letter regarding: _____ ☐ Other: _____ _____	☐ Confirming appointments ☐ Assessment info ☐ Medication info ☐ Progress and Treatment ☐ Dates attended ☐ Safety concerns ☐ Other: _____ _____

ACTION to be taken:
☐ VERBAL INFORMATION ONLY
☐ WRITTEN AND VERBAL INFORMATION

TO BE COMPLETED BY Beacon STAFF:
☐ WRITTEN AND VERBAL INFORMATION SENT BY HIM STAFF
☐ WRITTEN AND VERBAL INFORMATION SENT BY PROGRAM STAFF

DATE RANGE (Records of services provided between these dates):

_____ TO _____

(Needed for written information requests only)

This Authorization is valid for: ☐ One time ☐ Up to a year ☐ Other: _____ (Maximum of 1 year)

READ CAREFULLY
My signature below acknowledges my understanding of the following:

1. I understand that medical/behavioral health records are confidential. By signing this authorization, I am allowing the release of information, including any substance use information, to the agency or person specified above. Transfer of the information released above to persons or agencies not specified is prohibited by law.
2. I understand that signing this authorization is voluntary and is not a condition of receiving services here.
3. This authorization includes both information presently compiled and information to be compiled during the course of the client's treatment at this agency.
4. I understand that there is a potential for the information disclosed to be subject to redisclosure by the recipient and no longer protected by this law.
5. This consent is subject to revocation by the undersigned at any time by completing a separate notice of revocation. Any actions taken before revocation will not be affected.
6. This authorization to release information is subject to the following restrictions: _____
7. I understand that I have the right to request a copy of this authorization and to request to see or copy the information prior to its disclosure.
8. I understand that this authorization includes release of communicable disease information, such as HIV/AIDS.

SIGNATURES:

_____ _____
Client Signature Date Parent or Legal Representative Date

Person assisting Client with ROI: Name: _____ *Department:* _____

CLIENT NAME: _____ **CLIENT ID:** _____