BEHAVIORAL HEALTHCARE OPTIONS, INC.

RELEASE OF INFORMATION FOR MENTAL HEALTH RECORDS

READ THIS INFORMATION FIRST: The purpose of this authorization is to grant Behavioral Healthcare Options, Inc. (BHO) permission to disclose your Mental Health records, including any pertinent Medical and School records, to the party identified below in this request. Once completed and signed, this authorization will remain in effect until the earliest of: (a) the date you specify below; (b) one year from date signed; or (c) the date you revoke it. The information you authorize us to disclose may be subject to re-disclosure by the recipient and if the person or organization authorized to receive the information is not a health plan or health care provider, the information may no longer be protected by the Federal privacy regulations. You may revoke this authorization in writing at any time, however it will not have any effect on any actions BHO took in reliance on the authorization. You may refuse to sign this authorization, and BHO does not require signature of this document in order to provide treatment services. Information pertaining to substance abuse diagnosis or treatment requires completion of the Consent for Release of Confidential Health Information under 42 C.F.R. Part 2 - Confidentiality of Alcohol and Drug Abuse Patient Records.

PATIENT INFORMATION

Member Name (Parent/Guardian Name if Minor):			**Date of Birth:**
Street Address:	**Cell Phone:** ( )	**Home___ Work____ Phone:** ( )	
P.O. Box:	**City:**	**State:**	**ZIP Code:**

INFORMATION TO BE DISCLOSED

The purpose of this authorization is: (check all that apply)

- ☐ To assist with evaluation and treatment
- ☐ On-going verbal communication for continuity of care and treatment
- ☐ Other (explain reason for authorization):

The information to be disclosed is:	
☐ Medical History ☐ Diagnosis ☐ Progress Reports	☐ Social History ☐ Treatment Summary ☐ Other (Specify)

INFORMATION IS BEING SENT BY:

Name:	**Phone:**
Address:	**City State:** **ZIP Code:**

INFORMATION IS BEING SENT TO:

Name:	**Phone: ( ) FAX: ( )**
Address:	**City: State:** **ZIP Code:**

EXPIRATION (SELECT ONE)

This authorization will expire on (date):	☐ In one year	☐ Other (specify):

I acknowledge that the information to be disclosed was fully explained to me.

Member Signature: _____ Date: _____