BEHAVIORAL HEALTHCARE PROVIDERS

Please Fax Completed Form to BHP at 763-486-4439

Authorization to Release Protected Health Information

Date:	Patient Name: (First, Middle, Last)	Birth Date (MM/DD/YY)

Release Information From:

☐ BHP, 1405 N Lilac Dr, Suite 151, Golden Valley, MN 55422
P: 763-210-4690 F: 763-486-4439

Release Information To:

☐ Any provider BHP refers patient to

☐ Other (specify facility/individual & address below, including phone/fax if known)

_____
_____
_____
_____
_____
_____
_____

Purpose of Release:

☐ Treatment /Continue Care
☐ Other: _____

Information to be Released:

☐ DEC Assessment; including information relating to mental health or substance abuse assessments, and any follow up activities and/or appointments and referrals recommended as a result of a DEC Assessment.

I understand the information to be released may include records related to behavioral and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. This authorization will expire one year from the date of signing unless I revoke consent. Revocation must be made in writing to the provider/facility releasing the information.

I further understand that I agree to pay the facility the cost incurred by BHP in preparing the copy of requested mental/behavioral health records as allowed by State and Federal guidelines. The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by federal law.

I understand that no treatment, payment, enrollment, or eligibility for benefits may be conditioned on whether I sign this authorization.

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form. ***(You may be asked to provide documentation of your legal authority before any action is taken.)***

- **If the patient is 18 years of age or older,** the patient must sign and date the form.
- **If the patient is 18 years or older and is incapable of signing,** a legally authorized substitute may sign and date the form.

Please indicate your legal authority.

☐ Legal Guardian or Conservator ☐ Health Care Agent (Health Care Power of Attorney)

- **If the patient is 17 years of age or younger,** the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship:

☐ Parent ☐ Legal Guardian

Signature: _____ Date: _____

Printed Name: _____

Relationship to Patient: _____