Records Request: Authorization to Release Information

Complete this form for each provider, individual, or entity you would like BZA Behavioral Health to be able to communicate with.

Client Name: _____ **Date of Birth:** _____

I, _____, authorize provider, _____ at BZA Behavioral Health to share personal health information contained in my client record. I allow the sharing of verbal and written personal health information with:

Name: Records Deposition Service ← (Enter information for Providers/School/Individuals here)

Address: P.O. Box 5054 City/State/Zip: Southfield, MI 48086-5054

Phone Number: 248.357.3330 Fax Number: 248.357.3337 E: requests@recdep.com

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The following checked items may be disclosed: *(Select ALL that apply)*

☐ Treatment records	☐ Diagnosis information
☐ Assessment information and history	☐ Psychiatric evaluation
☐ Psychological Testing records	☐ Financial, insurance, and payment records
☐ Scheduling details	☐ Verbal communications only
☐ Other:_____	

For the purpose of:

☐ Continuity of care, evaluation, and/or treatment	☐ Financial and account management
☐ Educational, occupational,and/or legal advocacy & support	X Other: legal discovery

Refusal to consent to this authorization to release information will result in the inability to coordinate care and/or other consequences as explained by your treatment.

I understand that I have the right to inspect and copy the information disclosed and that my authorization may be revoked at any time. Such revocation will not affect materials disclosed prior to revocation. The authorization will otherwise remain effective from the date of my signature until _____. Under the provisions of the Illinois Mental Health and Developmental Disabilities Act, HIPAA, and applicable Federal and State Alcohol and Substance Abuse Confidentiality Acts, the person or facility receiving this information may not re-disclose this information without written authorization.

Signature (12 and older):* Date:

Signature of Responsible Party (If the client is a minor):* Date:

Witness:* Date: