



Behavioral Health and Education Specialists

14953 S. Van Dyke Road

Plainfield, Illinois 60544

(815) 609-1544 (Phone)

(815) 609-1670 (Fax)

www.bhes.us

info@bhes.us

Authorization For Release Of Private Health Information

Patient Name: _____

Date: _____

Patient Date Of Birth: _____

Phone #: _____

Address: _____ City/State/Zip: _____

I authorize BHES: To obtain from

To release to:

Name of person, institution, agency, etc.

Phone #: _____

Address, City, State, Zip

Fax #: _____

I authorize release of my Private Health Information and/or copies thereof to be delivered via:

Verbal Fax U.S Mail Email In Person (Photo Id Required)

I, the undersigned, understand the purpose for releasing my Private Health Information is:

Continuity of Care Personal Reasons Insurance Legal Aid in Treatment Other _____

Confidential Information Authorized For Release:

Initial Intake Psychiatric Evaluations Psychological Evaluations/Testing Psychiatric Progress Notes
 Psychological Progress Notes Medical Progress Notes Psychological Testing Data Referral For Services
 Discharge Summaries School Records and Testing Lab Work/Results Service Plans Treatment Plans
 Information Shared During Treatment Sessions Other: _____

I understand I will be informed of requests for information and I may, upon my written request, review the disclosed information. I understand I have the right to inspect and/or receive a copy of the Private Health Information to be used or disclosed and also to receive a copy of this authorization form. I understand that information used or disclosed related to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by law. I understand I have the right to revoke this authorization at any time by notifying Behavioral Health and Education Specialists, Inc., in writing, of my decision. I understand that any release made prior to my revocation shall not constitute a breach of any rights of confidentiality. I understand I may decline to sign this Authorization and that this decision will not affect the services provided to me in any way. I want to limit (or specify) records to be released in the following way(s) (i.e.: records after a certain date or relating to certain conditions): _____

This Authorization expires one year from the date of signature unless otherwise specified: _____

I acknowledge I have read and fully understand the above information as it applies to me and consent to the release of records for the purpose(s) stated above.

Patient Signature (12 years old and older)

Date

Witness Signature

Date

Parent/Guardian Signature (Under 12 years old)

Date

Relation to Patient