Behavioral Health and Education Specialists
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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:

_____ Phone #: _____
Name of person, institution, agency, etc.

_____ Fax #: _____
Address, City, State, Zip

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 redisclosure 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 they apply 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