BEBH Authorization
For Disclosure Of Mental Health Treatment

Information I,_____, whose Date of Birth is authorize to disclose to

and/or obtain from _____the following information:

Description of Information to be Disclosed

(Patient/Client should initial each item to be disclosed)

_____Assessment
_____ Diagnosis
_____Psychosocial Evaluation
____-`_Psychological Evaluation
_____ Psychiatric Evaluation
_____Treatment Plan or Summary
_____Current Treatment Update
_____ Medication Management Information
____ Presence/Participation in Treatment
_____Nursing/Medical Information

_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____Progress in Treatment
_____ Demographic Information
_____Psychotherapy Notes*
(*Cannot be combined with any other disclosure)
_____Other_____
_____Other_____

Purpose

This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations.

If the purpose is other than as specified above, please specify:
Care coordination, exchange of relevant information with guardian ad litem

_____

_____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to at . I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date: 6/8/2022 or as otherwise indicated:_____

Conditions

I further understand that Box Elder Behavioral Health will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: treatment communication may be affected

_____

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____ Check here if patient/client refuses to sign authorization