BEHAVIORAL MEDICINE RELEASE OF PATIENT INFORMATION

Stevens Community Medical Center
400 East First Street, Morris, MN 56267 PHONE (320) 589-7625 FAX (320) 589-7686

Patient Name (Last - First – Middle)		Previous Last Name (if any)	
Street Address/Rural Route		Telephone	Birth Date
City	State	Zip Code	Chart #

By my signature below, I hereby authorize SCMC Behavioral Medicine Department / _____
to **obtain from** / **release to** / **exchange with**:

_____
Name/Agency Address

information concerning myself and/or family members (under the age of 16) as indicated:

Name	**Date of Birth**	**Name**	**Date of Birth**
_____	_____	_____	_____
_____	_____	_____	_____

Information to be obtained / released / exchanged (put your initials by information to release):

_____ Admit / Discharge Summaries _____ Progress Reports _____ CD Assessments
_____ Psychological/Psychiatric Testing _____ Court Reports/Orders _____ Treatment Plans
_____ Diagnostic Assessment _____ Verbal Communication
_____ Medical Information (specify) _____
_____ Other (specify) _____

Information to be used for:

_____ Treatment & Related uses _____ Collateral Contact _____ Referral _____ Insurance Purposes
_____ Other (specify) _____

THE FOREGOING IS SUBJECT TO SUCH LIMITATIONS AS INDICATED BELOW: *(PLEASE CHECK AT LEAST ONE.)*

☐ 1. NO LIMITATIONS placed on dates, history of illness, diagnostic and therapeutic information, INCLUDING but not limited to that which involves treatment for alcohol or drug abuse, or psychological and/or psychiatric conditions. (Patient/Legal guardian must sign for authentication of this response.)
Signature: _____
☐ 2. Confined to records regarding admission and treatment for the following medical condition: _____
_____
☐ 3. Covering records for the period from _____ (date) to _____(date)
☐ 4. Confined to the following specified information: _____

I understand that I can cancel this release at any time by notifying the provider in writing and that my cancellation will take effect when the provider receives my written notice. I understand that my cancellation will not have any effect upon information released before the provider received my written notice.

I DO NOT AUTHORIZE FURTHER RELEASE TO ANY OTHER THIRD PARTY.

I understand that the hospital/clinic and its employees, and my attending physician and his/her associates who participated in my care, cannot be responsible for confidentiality of information disclosed after said information has been released pursuant to this authorization, and I hereby release them from any liability arising from such disclosure.

I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following, date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in one year.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. Treatment will still be provided to me if I do not sign this form. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that if the person or organization I authorize to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and could be re-disclosed.

Signature of person releasing information	Date signed	Witness
Relationship to patient, if signed by other person	Reason patient unable to sign	

A COPY OF MY SIGNATURE IS AS VALID AS THE ORIGINAL

NOTICE TO PROVIDERS: The information you provide pursuant to this release may be viewed by the patient unless you specify in writing the statutory basis for withholding the information from the patient.

Routing: Beh Med initial/date and then scan into eCW (Beh Med – Release of Information) →
if Therapist → file in chart; if Dr. Stein → shred beh10 (9-97) rev 4-17
Please note: If past records need to be released, assign to SJohnson