I hereby authorize (company getting info from)_____ fax number _____

to release my information to (Our Company Name) ___BRC Mental Health Services_____

Located at (Address) ____963 S. Orchard St. Ste. 103 Boise, ID 83705_____phone: (208) 890-7290_____

Patient's Full Name: _____ Date of Birth:_____
Address: _____
Telephone Number:_____

The purpose for which the following information is being requested: ___Coordination of Care and to start Mental Health Services with BRC_____
I authorize the following information to be released from my mental/behavioral health records:
Date(s) of Service(s): _____

Physical and Mental Health and/or Drug and Alcohol Treatment Records that are authorized to be released:
Please check the appropriate item(s):

History and Physical	Psychosocial Assessment	Medications
Psychiatric Eval/Tests	Psychosocial Eval/Tests	Progress Notes
Psychological Testing Results	Physician Orders	Labs
Alcohol/Drug Assessments	Alcohol/Drug Treatment Records	Treatment Plan
Psychotherapy Notes	Group Therapy Notes	Discharge Summary

Other (Please Specify): _____

The designated information about me may may not be transmitted by fax, electronic mail or other electronic file transfer mechanisms. (Company name)_____ and the above designated person may may not discuss by telephone the content of the information released.

This consent is in effect until_____. I understand that I may revoke this authorization, in writing, at any time unless action based on it has already take place. I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original.

The facility, agency, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by federal law, except for drug and alcohol treatment information.

I understand that I am entitled to a copy of this authorization.

Printed Name:_____

Patient/Parent/Guardian/Legal Representative Signature: _____

Date:_____ Relationship to Patient:_____

Please fax information to (208) 286-9829 .