



# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

## 1. CLIENT/PATIENT INFORMATION

Legal Name (First, Middle, Last): \_\_\_\_\_ Date of Birth (mm-dd-yyyy): \_\_\_\_\_

List any aliases or previous names you have used: \_\_\_\_\_

Address (Street, City, State, Zip Code): \_\_\_\_\_

Email (unless otherwise specified, records will be delivered via secure email): \_\_\_\_\_

## 2. RELEASE PURPOSE

Personal  Legal  Continuity of Care  Other (specify): \_\_\_\_\_

## 3. WHO DO YOU WANT TO RELEASE YOUR INFORMATION? (select only one)

Centerstone & affiliates (specify):  Adult & Child Health  Burrell Behavioral Health  Centerstone  
 Firefly  Places for People  Preferred Family Healthcare  Southeast Missouri Behavioral Health

Other (specify): Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_

## 4. WHO DO YOU WANT YOUR INFORMATION GIVEN TO? (select only one)

Myself (client/patient)

Other (specify): Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_

## 5. DELIVERY METHOD

US Mail (address): \_\_\_\_\_

Secure Email Address: \_\_\_\_\_  FAX Number: \_\_\_\_\_

Pick up at location (specify): \_\_\_\_\_  Verbal Communication

Other: \_\_\_\_\_

## 6. EXPIRATION

Unless otherwise revoked, this authorization will expire 1 (one) year from the date signed or on:

Expiration Date: \_\_\_\_\_ or  Expiration Event: \_\_\_\_\_

## 7. TIMEFRAME AND TYPE OF RECORDS TO BE RELEASED

**Timeframe** (select one)  All records within these dates of service (mm-dd-yyyy) \_\_\_\_\_ to \_\_\_\_\_

All past, present, and future records

**Type of Records:**

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Treatment/Service Dates    | <input type="checkbox"/> Complete Record    | <input type="checkbox"/> Medication List   | <input type="checkbox"/> Immunizations                        |
| <input type="checkbox"/> Psychological Evaluations  | <input type="checkbox"/> Lab Results        | <input type="checkbox"/> Treatment Plans   | <input type="checkbox"/> Housing                              |
| <input type="checkbox"/> Metabolic/Health Screening | <input type="checkbox"/> Assessments        | <input type="checkbox"/> Imaging Reports   | <input type="checkbox"/> Employment                           |
| <input type="checkbox"/> Progress Toward Goals      | <input type="checkbox"/> Progress Notes     | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Reports<br>(Court/School/ Probation) |
|   | <input type="checkbox"/> Crisis/Safety Plan | <input type="checkbox"/> Diagnoses         |   |

Other (specify): \_\_\_\_\_

I authorize the release of any of the above marked records that contain information related to alcohol/substance use including urine drug screenings/drug test results/non-compliance with treatment.



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I authorize the release of any of the above marked records which may indicate the presence of communicable, non-communicable, or venereal diseases including but not limited to HIV/AIDS.

**8. SIGNATURE AND DATE:** Please read the following statements carefully before signing this form.

This authorization may be revoked at any time, except to the extent that the agency has taken reliance on it, by executing an electronic written revocation, or by providing written notice of revocation to: Health Information Department, 1111 S. Glenstone Ave., Springfield, MO 65804. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law. 42 CFR Part 2 prohibits the unauthorized redisclosure of alcohol/substance use disorder treatment records. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether or not you sign this authorization. You may request a copy of this signed authorization & you have the right to inspect and receive a copy of the material to be disclosed. We may charge for copies of records in accordance with state law. Note: A patient/client (18 years or older) must authorize the release of their own records unless incapacitated or deceased. If signing for a minor, I hereby state that my parental rights have not been revoked by a court of law. Specific situations may require minor's authorization. **Signature dates are required (mm/dd/yyyy).**

Client/Patient Signature:		Date:
Legal Gdn./Rep. Signature:		Date:
Printed Name:	Relationship to Client/Patient	
	<input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Legal Authorized Rep.	
<input type="checkbox"/> Check this box if client/patient is deceased.		

**IMPORTANT:** Any authorization with alterations must have the alterations initialed by the client or guardian. Alterations that are not initialed will be invalid.

Please contact ROI/Medical Records at the address/phone number listed below if you have questions.

**833-763-0418 | Fax: 660-677-4005 | [MedicalRecords@livebrightli.org](mailto:MedicalRecords@livebrightli.org)**