CENTERSTONE

MRN: ______________ DOB: ______________

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)

☐ 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:

	☐ Complete Record	☐ Medication List	☐ Immunizations
☐ Treatment/Service Dates	☐ Lab Results	☐ Treatment Plans	☐ Housing
☐ Psychological Evaluations	☐ Assessments	☐ Imaging Reports	☐ Employment
☐ Metabolic/Health Screening	☐ Progress Notes	☐ Discharge Summary	☐ Reports (Court/School/ Probation)
☐ Progress Toward Goals	☐ Crisis/Safety Plan	☐ 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.

☐ 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.

Note: This is a 2-page form and is not valid without both pages.

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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 ☐ Parent ☐ Legal Guardian ☐ Legal Authorized Rep.
☐ 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