BOSC
Mental Health

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Patient Date of Birth: _____

I authorize my provider(s) and staff at BOSC Mental Health to release and/or receive information (medical, mental health, and addiction-related information) to/from:

Name: _____ Phone: _____

Address: _____ Fax: _____

Information to be released (check one or more):

___ Any/all treatment-related records or information (history, evaluations, all notes, studies, lab work, diagnosis, formulations, treatments, payment information, email correspondence and others [my entire medical record]).
___ A summary of relevant parts of my care (relevance determined by my provider)
___ Other: _____

Purpose of disclosure (check one or more):

___ To coordinate/plan care with other providers (for example with my therapist, specialist, or primary care provider)
___ To secure medical leave or disability (such as FMLA or medical leave from school)
___ Transition of care to a new provider
___ Other (i.e. legal, school/workplace accommodations): _____

I understand that the parties above may participate in periodic exchanges of information (written or verbal) for the purposes described above.

I understand that I have a right to meet with my clinician to inspect my medical, mental health and addiction treatment record.

I understand that BOSC Mental Health providers/staff cannot be held responsible for negative consequences, including legal liability, that may arise as a result of their compliance with this request.

I understand that this consent may be revoked at any time, but any action that has been taken in reliance thereon cannot be changed.

By signing below, I attest that I have read this form, understand its content, and request that the above information be released/exchanged as specified.

Signature: _____ Date: _____
Typing Your Name Here Constitutes Legal Signature

Witness: _____ Date: _____
Typing Your Name Here Constitutes Legal Signature