Behavioral Dimensions

Authorization for USE and DISCLOSURE of Protected Health Information

Patient Name:_____ Date of Birth:_____
Last First MI

_____
Address City State Zip

I hereby authorize:

Contact Name:_____Facility/Agency:_____

Address:_____

Phone:_____Fax:_____

To release information to:

Contact Name:_____Facility/Agency: Behavioral Dimensions, Inc

Address: 7010 Highway 7 St. Louis Park, MN 55426 Phone: 952-814-0207 Fax: 952-938-8838

Purpose of Disclosure: (Check all that apply)

____Coordination of Care ____Payment of Claim ____School ____Verification of Service Eligibility

____Legal ____Continuing Care ____Other:_____
Specify

Information to be Released: (Check all that apply) **Between the Dates of:_____and_____**

____Discharge Summary ____Exam/Initial Evaluation ____Consult ____Counselor/Therapist Reports

____Progress/Provider Notes ____Diagnostic Test Reports ____Procedure Reports ____School Reports

____Correspondence ____Psychological Testing ____Transfer Information ____Completed Forms

____Any verbal or written information pertinent to completing an assessment and/or program recommendations

____HIV Related Information ____Other:_____

☐ **I authorize the parties listed above to release and/or exchange the information above in written and/or verbal form—essentially creating a two-way exchange of information.**

Acknowledgment of Understanding:

I understand the expiration date of this authorization is _____ or 1 year from today's date, whichever is sooner.
I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance on it.
I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer protected by Federal privacy regulations.
I understand that Behavioral Dimensions may not place conditions on my payment, enrollment, or eligibility for benefits on my signing this authorization.
I understand that I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of records.
I understand a photocopy or a fax of this form is the same as the original.

If I am signing as an Authorized Representative of the Patient, I am:

____Parent of minor ____Court appointed guardian/conservator

☐ **I request a copy of this form to be mailed to the address listed at the top of this form.**

_____ _____
Patient or Parent/Guardian Signature Relation to Patient Date