



RED BIRD

Mental Health

Authorization for Release of Information

I, _____ (Client or guardian) authorize Red Bird Mental Health Services, LLC (“RBMH”) to obtain and/or disclose _____ (Name of Client) health information only as described below. This release is valid from _____ until _____. This release of information covers the following information:

- | | | |
|---|---|---|
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Treatment Plans | <input type="checkbox"/> Psychiatric Updates |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Psychosocial evaluations | <input type="checkbox"/> Physicals |
| <input type="checkbox"/> Immunizations | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Client’s History |
| <input type="checkbox"/> Dates of Treatment | <input type="checkbox"/> Client’s Progress | <input type="checkbox"/> Psychiatric Addendum |
| <input type="checkbox"/> Educational
Records/Evaluations | <input type="checkbox"/> Other: | |

RBMH is authorized to disclose and obtain information from the following agency/provider:

Name: _____

Address: _____

Phone: _____ Fax: _____

The purpose of this release is:

- | | |
|---|---|
| <input type="checkbox"/> Coordination of treatment/services | <input type="checkbox"/> Payment for Services |
| <input type="checkbox"/> Referral to other agency | <input type="checkbox"/> Insurance |
| <input type="checkbox"/> Court Order | <input type="checkbox"/> Other (specify) |
| <input type="checkbox"/> Pending Legal Issues | |

Client’s rights:

1. I understand that I have the right to revoke this release at any time. I may not revoke it to the extent that RBMH has already relied upon it, or if this release was signed as a condition of obtaining insurance coverage. In order to revoke this release, I understand that I must revoke it in writing to RBMH.
2. I understand that RBMH may not require that I sign this release in order to obtain treatment, and that, with certain limited exceptions, I have the right to inspect the information disclosed (or get a copy at my expense).
3. I understand that information used or disclosed under this release could potentially be re-disclosed by the person receiving the information, and may no longer be subject to the privacy protections provided to me by law.

Client Signature: _____ Witness: _____

Client’s Printed name: _____ Date: _____

If you are the legal representative of the person listed above, please check of the basis for your authority:

- Power of Attorney (attach copy) Parent of Minor Guardianship Order
 Other: _____