**AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI)**

The undersigned hereby authorized Behavioral Health System Baltimore, Inc. (BHSB) to disclose to **Click here to type name**. the information below with regard to:

Individual’s Full Name: **Click here to type name.** Date of Birth: **Click here to enter DOB.**

PHI To Be Released – Covering the Periods of Healthcare

FROM: (date) **Click to enter date.** TO: (date) **Click to enter date.**

Information To Be Disclosed

**Click here to identify PHI to be disclosed in a specific and meaningful fashion.**

Purpose of Disclosure

[ ]  Treatment or Consultation [ ]  Billing or Claims Payment [ ]  At individual’s request

[ ]  Other, (please be specific): **Click here to specify other purpose for disclosure.**

Who and Where to Send/Release Information

Name(s) **Click here to type name(s).**

Address: **Click here to type address.** Telephone #: **Click here to type telephone #.**

Time Limit, Right to Revoke and Conditions

Except to the extent that action has already been taken in reliance on this Authorization, I can revoke this Authorization at any time by submitting written notice to **Click here to type name**. Unless revoked, this Authorization will expire on **Click here to enter expiration date.**I understand that the disclosure of the above information is voluntary. I can refuse to sign this Authorization. **I do not need to sign this Authorization to assure treatment, payment, enrollment, or eligibility for benefits.**  I understand that I may inspect or copy the information to be used or disclosed as provided by C.F.R. 164.524. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by the confidentiality rules.

Signature of Individual or Legal Representative Who May Authorize Disclosure

**I understand this Authorization, and I authorize BHSB to release the information specified above.**

Signature: Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Relationship to Individual if Legal Representative:

*Proof of authority is required of Legal Representatives.*

*A signed copy must be provided to the Individual.*