B.P.R. Therapy, Mediation & Coaching Services

Authorization to Disclose

I _____ authorize and request that Bryan P. Range, and private practitioner, to disclose/receive the below specified Protected Health Information. The specific information to be disclosed/received is:

___ Discharge Summary
___ Treatment Summary/Therapeutic Contract
___ Transfer Summary
___ Educational Testing (IEP, transcript, grading reports)
___ Social Service Assessment
___ Summary of extent of service
___ Medical Assessment
___ Psychiatric Assessment
___ Other: _____

Check which applies:

___ Disclose/Release to: ___ Receive From:

To/From: _____
Name of facility, agency, or person

_____
Address

_____
City State Zip Code

The purpose of this disclosure is:

___ Continuity of services/care ___ Transfer/Treatment
___ At Client's Request ___ Assessment
___ Treatment Planning
___ Other: _____

Email: bpr@bprtmcs.com
Phone: (319) 331-5950

I understand that my medical/health information records are confidential. I understand that by signing this authorization, I am allowing release of my medical/health information. The Protected Health Information (PHI) in my medical records includes mental/behavioral health information. This authorization includes both information presently compiled and information to be complied during the course of treatment at the above-named agency during the specified time frame.

I understand that this consent is voluntary and that I may withdraw it at any time in writing. I further understand that actions already taken based on this authorization, prior to revocation, will not be effected. If I fail to specify an expiration date, this authorization will expire in 6 months.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that I have the right to receive a copy of this authorization.

This authorization becomes effective on _____. This authorization expires on the following date _____.

My signature below acknowledges that I have read, understand, and authorize to disclose/receive my PHI.

Print Name, Client	Client Signature	Date

Legal Guardian/Print Name	Legal Guardian Signature	Date

Print Name, Witness	Witness Signature	Date

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Phone: (319) 331-5950

NOTICE OF REVOCATION

I _____ (client) hereby revoke my authorization of this disclosure of information to the facility/agency/person listed above. This revocation effectively makes null and void any permission for disclosure of information given by the above authorization.

Print Name, Client	Client Signature	Date
Legal Guardian/Print Name	Legal Guardian Signature	Date
Print Name, Witness	Witness Signature	Date

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