



# BEHAVIORAL MEDICINE RELEASE OF PATIENT INFORMATION

Stevens Community Medical Center  
400 East First Street, Morris, MN 56267 PHONE (320) 589-7625 FAX (320) 589-7686

Patient Name (Last - First - Middle)		Previous Last Name (if any)	
Street Address/Rural Route		Telephone	Birth Date
City	State	Zip Code	Chart #

By my signature below, I hereby authorize SCMC Behavioral Medicine Department / \_\_\_\_\_  
to **obtain from / release to / exchange with:**

\_\_\_\_\_  
Name/Agency Address

Information concerning myself and/or family members (under the age of 16) as indicated:

Name	Date of Birth	Name	Date of Birth
_____	_____	_____	_____
_____	_____	_____	_____

**Information to be obtained / released / exchanged** (put your initials by information to release):

_____ Admit / Discharge Summaries	_____ Progress Reports	_____ CD Assessments
_____ Psychological/Psychiatric Testing	_____ Court Reports/Orders	_____ Treatment Plans
_____ Diagnostic Assessment	_____ Verbal Communication	
_____ Medical Information (specify) _____		
_____ Other (specify) _____		

**Information to be used for:**

\_\_\_\_\_ Treatment & Related uses    \_\_\_\_\_ Collateral Contact    \_\_\_\_\_ Referral    \_\_\_\_\_ Insurance Purposes

\_\_\_\_\_ Other (specify) \_\_\_\_\_

**THE FOREGOING IS SUBJECT TO SUCH LIMITATIONS AS INDICATED BELOW: (PLEASE CHECK AT LEAST ONE.)**

- 1. NO LIMITATIONS placed on dates, history of illness, diagnostic and therapeutic information, INCLUDING but not limited to that which involves treatment for alcohol or drug abuse, or psychological and/or psychiatric conditions. (Patient/Legal guardian must sign for authentication of this response.)
- Signature:** \_\_\_\_\_
- 2. Confined to records regarding admission and treatment for the following medical condition: \_\_\_\_\_
- 3. Covering records for the period from \_\_\_\_\_ (date) to \_\_\_\_\_ (date)
- 4. Confined to the following specified information: \_\_\_\_\_

I understand that I can cancel this release at any time by notifying the provider in writing and that my cancellation will take effect when the provider receives my written notice. I understand that my cancellation will not have any effect upon information released before the provider received my written notice.

**I DO NOT AUTHORIZE FURTHER RELEASE TO ANY OTHER THIRD PARTY.**

I understand that the hospital/clinic and its employees, and my attending physician and his/her associates who participated in my care, cannot be responsible for confidentiality of information disclosed after said information has been released pursuant to this authorization, and I hereby release them from any liability arising from such disclosure.

I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following, date, event, or condition: \_\_\_\_\_. If I fail to specify an expiration date, event, or condition, this authorization will expire in one year.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. Treatment will still be provided to me if I do not sign this form. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that if the person or organization I authorize to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and could be re-disclosed.

Signature of person releasing information	Date signed	Witness
Relationship to patient, if signed by other person	Reason patient unable to sign	

**A COPY OF MY SIGNATURE IS AS VALID AS THE ORIGINAL**

**NOTICE TO PROVIDERS:** The information you provide pursuant to this release may be viewed by the patient unless you specify in writing the statutory basis for withholding the information from the patient.

Routing: Behavioral Medicine initial/date → HIM to scan into Chart Maxx  
(MH Release of Information Authorization - S) → Shred      beh10 (9-97) rev 2-19



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