



## Behavioral Health and Education Specialists

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### Authorization For Release Of Confidential Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

I authorize BHES:  To obtain from  To release to:

\_\_\_\_\_  
Name of person, institution, agency, etc... Phone #: \_\_\_\_\_

\_\_\_\_\_  
Address, City, State, Zip Fax #: \_\_\_\_\_

I, the undersigned, authorize release of information and/or copies of the following to be transmitted via:

Verbal  Fax  Mail  Email

#### Confidential Information Authorized For Release:

Initial/Intake Assessments or Evaluations  
 Psychiatric Evaluations  
 Psychological Evaluations  
 Psychiatric Progress Notes  
 Psychological Progress Notes  
 Medical Progress Notes  
 Psychological Testing Data  
 Treatment Plans

Discharge Summaries  
 School Records and Testing  
 Service Plans  
 Referral For Services  
 Other: \_\_\_\_\_  
\_\_\_\_\_

I understand I may revoke this authorization at any time by notifying my Behavioral Health Professional, in writing, of my decision. I understand that any release made prior to my revocation shall not constitute a breach of any rights of confidentiality. I understand I will be informed of requests for information and I may, upon my written request, review the disclosed information. I understand I may decline to sign this Authorization and that that decision will not affect my psychological examination in any way.

I want to limit (or specify) records to be released in the following way (i.e.: records after a certain date or relating to certain conditions): \_\_\_\_\_

The records are to be released to assist in the psychological examination and this Authorization automatically expires one year from the date of signature unless otherwise specified:

\_\_\_\_\_  
Patient Signature (Parent/Guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date