Oak Hills Behavioral Health Solutions, LLC
Communication. Trust. Teamwork.
1513 Union Ave., Suite 2500
Moberly, MO 65270
Ph (660) 372-1313 Fax (660) 372- 1339

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to the Counseling Center by other individuals or agencies. Such requests should be referred to the original individual or agency.

I,____(Client/Guardian) DOB:______________

Authorize OHBHS to release PHI information to: Name/agency ______________________

Contact information/ address/ ph/ fax ____

____

Authorize(name/agency):____

__________________ **to Release PHI information to:** Oak Hills Behavioral Health Solutions LLC; 1513 Union ave. Ste 2500, Moberly, MO., 65270

The following information is to be released:

_____ History/intake
_____ Treatment summary
_____ Diagnosis
_____ Psychiatric evaluation/medication history
_____ Dates of treatment attendance
_____ Other (specify) ______________________________
For the purpose of:_____ Evaluation/assessment/Coordination of treatment efforts/Ongoing treatment; and/or,
Other (specify): ____
This consent will automatically expire **one (1) year** from this date:________________

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

I request the documentation to be released in the following manner:

____Copies (MAIL) ___Copies (FAX) ___ Copies to be picked up: ___Verbal:____Other:_____EMail:____

Consumer Name:____ DOB:________________

Signature of Consumer and/or GuardianRepresentative:______________________________Date:_________

Witness:____ Date:________________