

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 _____ to release PHI information to:
Name/agency _____
Contact information/ address/phone/fax: _____

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): _____

Unless otherwise specified, his consent will automatically expire one (1) year from date of signature.

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

Guardian Representative: _____ Date: _____

Witness: _____ Date: _____