Bevill and Associates LLC
AUTHORIZATION FOR RELEASE OF MENTAL HEALTH INFORMATION

I hereby grant my permission for release, review and exchange of the following information relating to my care between the parties named here. This release is intended to cover all services provided by Bevill and Associates LLC C which includes services provided by Bevill and Associates LLC, Peter Boyle, Candice Lawhorn, Cheri Flow, Hanna Stitlner.
Charges for records requests may apply.

I am aware that once this information is released to another party, it may no longer be protected. I understand that I may further limit the type of exchange between the listed parties. List limitation, if any:
_____.

Bevill and Associates LLC	**AND**	
Phone: 205-610-9319 FAX: 205-610-9319		Phone: FAX:

Purpose of this request: (check all that may apply during the timeframe of this release)

Continuity of Care / Treatment | Legal | Insurance Claim | Patient Request | Other, specify:_____

Ways information may be shared: (check all that may apply during the timeframe of this release)

Mail | Fax | Phone | In Person | Picked Up | Shared via Community Patient Health Information Network or Approved Health Information Exchange Network

Sent to client via unencrypted e-mail (client request only)

Provided to client via unencrypted CD, USB or flash drive (client request only & client pick-up only). Charges for device will apply.

Patient's Name:		Date of Birth:	
Name at time of treatment:		Social Security #:	
Patient's Address:		Phone #:	

❒ **Date Range of Released Information: from _____**(Bevill and Associates admission date) **to Bevill and Associates Discharge Date** (same episode of care);

❒ **Other Date Range of Released Information: from _____ to _____.**

This information MAY include treatment or rehabilitation for drug and/or alcohol abuse, psychiatric treatment, Forensic Assessments and related conditions, IF they did occur. I specify that this release/exchange is to include:

Mental Health (MH) Assessment	Psychiatric Evaluation	Court records
MH Treatment Progress / Notes	Drug/Alcohol Abuse Assessment &/or Treatment	Occupational Therapy Evaluation &/or Treatment
Treatment Plan - ISP	Occupational Therapy Evaluation &/or Treatment	School records / IEP/outcome measures/ progress
Discharge Summary	Consultation	

Other Specified here: _____

Federal confidentially regulations prohibit the recipient of this released information from making any further disclosure unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

I understand that this authorization may be revoked at any time in writing, except to the extent that the program or person who is to make the disclosure has already acted in reliance on it. This authorization will remain in effect for 180 days after I sign and date the form below or until _____. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment. I understand that I may revoke my authorization at any time and for any reason. I understand that I can lengthen or shorten the authorization period by date, event, or condition.

_____

Signature/Client Date

_____

Signature Parent/Guardian Date

_____

Witness Date

Extended Date From _____ to _____ Signature _____ Date _____

If the signature is not that of the client/patient, explain, including authority to sign on behalf of the client and documentary evidence provided. k