BHSI - Behavioral Health Services

BHSI Eagan
3460 Washington Dr. Suite 200
Eagan, MN 55122
(651) 769-6200
(651) 769-6249 Fax

BHSI Brooklyn Center
6300 Shingle Creek Pkwy Suite 370
Brooklyn Center, MN 55430
(651) 769-6250
(651) 769-6299 Fax

BHSI Golden Valley
8441 Wayzata Blvd Suite 140
Golden Valley, MN 55426
(651) 769-6300
(651) 769-6349 Fax

BHSI North St. Paul
2497 7th Ave E, Suite 101
North St. Paul, MN 55109
(651) 769-6400
(651) 769-6449 Fax

BHSI Shakopee
327 Marschall Road S, Suite 250
Shakopee, MN 55379
(651)769-6500
(651) 769-6549 Fax

Authorization for Release of Confidential Information

I, _____

Authorize Behavioral Health Services to:

☐ disclose information to
☐ obtain information from
☐ exchange information with

_____
(Name of Person or Agency)

_____
(Address) (Phone or fax number)

Regarding: myself, _____

son/daughter;_____

other;_____

Date of Birth: _____ Treatment date(s) from _____ to _____

The information to be disclosed is:

_____ **All** medical records, to include mental health evaluation and treatment, concerns about chemical use, HIV/AIDS and STD, and genetic information.

OR

To only release specific portions of your health information, indicate the categories to be released:

☐ Diagnostic Impressions ☐ Progress Notes ☐ HIV/AIDS testing
☐ Medication History ☐ Discharge summary ☐ Psychological testing
☐ Mental Health Record ☐ Medical History ☐ Physical Examination
☐ Academic Record/ School Functioning
☐ Court Evaluations and/or Dispositions
☐ Chemical Dependency Program Information
☐ Other _____

The purpose of the disclosure is: _____

I understand that I may revoke this consent at any time by written notice. Without an expressed revocation (unless information has already been released) it will expire after twelve months. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. I understand that BHSI may not condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization.

Release of information on chemical dependency, HIV/AIDS, or reproductive health in the case of a minor also requires the minor's signature.

_____ _____
(Date) (Signature of Patient, Parent or Guardian)

_____
(Signature of Witness)