BEHAVIORAL HEALTH SYSTEMS

Behavioral Healthcare Programs for Business & Industry Since 1989

PATIENT INFORMATION

ABOUT THE PATIENT:

Name (L/F/M): ______________________________

Patient SS#: ______________________________

Home Address: ______________________________

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Home Phone #: ______________________________

Office Phone#: ______________________________

E-Mail Address: ______________________________

Emerg. Contact: ______________________________

Date of Birth: ______________________________

Marital Status: ❑Married ❑Single ❑Divorced ❑Widowed ❑Separated

Sex: ❑Male ❑Female

Relationship to Insured: ❑ Self ❑ Spouse ❑Child ❑Other

Other Insurance Coverage: ______________________________

Patient's Legal Guardian: ______________________________
(if applicable)

ABOUT THE INSURED:

Name (L/F/M): ______________________________

Insured SS#: ______________________________

Home Address: ______________________________

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Home Phone #: ______________________________

Office Phone#: ______________________________

Date of Birth: ______________________________

Marital Status: ❑Married ❑Single ❑Divorced ❑Widowed ❑Separated

Employer Name: ______________________________

Hire Date: ______________________________

Type of Coverage: ❑Individual ❑Family ❑Indiv & Spouse

Guardian Relationship to Patient: ____________________ Referred By: ______________________________

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize ____________________________ to disclose my individually identifiable health information to the utilization agents of BHS. The health information to be provided includes information as to diagnosis, treatment and prognosis regarding my mental/nervous/substance abuse condition and/or treatment. It does not include the release of actual psychotherapy notes. I understand BHS will use this information for purposes of approval of coverage, processing of claims for benefit purposes, and other payment and health care operations.

Information to be provided: ❑Clinical Assessment, ❑Recommended Treatment Plan, ❑Progress Notes for dates of service related to the Recommended Treatment Plan, ❑Complete Medical Record dated ________________________.

I understand that: (a) I may keep a copy of this form after I sign it, and/or I may request a copy from BHS; (b) treatment, payment, enrollment, or eligibility for benefits is not conditioned on my signing this authorization; (c) the information used or disclosed under this authorization may be subject to redisclosure by BHS and no longer protected by federal privacy regulations; and (d) I may revoke this authorization at any time by notifying BHS in writing, as described below. This will not affect any action BHS took prior to receiving the revocation.

I understand that this authorization will expire on the earlier of (a) the date set by applicable state law, or (b) completion of the recommended treatment and all related payment activities.

____ ____________________

Signature of patient or personal representative — Date

____ ____________________

Printed name of personal representative — Relationship to patient

If you have any questions or wish to revoke this authorization, please contact the Vice President, Clinical Services, at the address/phone number shown below.

R01-1 (08/208)