BellVue Health PLLC

984-250-6460 | admin@bellvuehealth.com

CLIENT & REFERRAL FORMS

Authorization to Share Records

Client full name

Date of birth

Who may disclose and receive information?

Disclosing person / organization (include BellVue if applicable)

Disclosing organization contact / address

Receiving person / organization (include BellVue if applicable)

Receiving organization contact / address

Information and purpose

Records authorized (select only what is needed)

☐ Assessment ☐ Person-Centered Plan ☐ Service notes ☐ Medication list

Other specific records / limits

Records date range

Purpose of disclosure

Expiration date or event (required)

This authorization excludes separately maintained psychotherapy notes and substance use disorder records protected by 42 CFR Part 2; use a separate applicable authorization for those records.

Signing is voluntary. Treatment, payment, enrollment, and benefit eligibility will not be conditioned on signing. I may revoke in writing to each disclosing organization; for BellVue, contact the Privacy Officer at admin@bellvuehealth.com or 984-250-6460 for secure delivery. Revocation does not undo actions already taken in reliance on this authorization. Information may be redisclosed by the recipient and may no longer be protected by HIPAA, although other laws may still apply. I am entitled to a copy of this signed authorization.

Client / authorized representative signature

Date (MM/DD/YYYY)

Representative printed name / relationship

Authority to act (if not client)

Use separate authorizations for additional disclosure directions or specially protected records.