OASIS
Behavioral Health Services

Authorization for Release of Information				
Patient Name (PRINT):				
DOB:	Last 4 digits of SSN:			
is authorizing **Oasis Behavioral Health Services, LLC** to release information:	☐ **To**	☐ **From**	☐ **Both**	

Name of Person/Organization/Facility:			
Phone:	Fax:		
Address:	City:	State:	Zip:
The information to be disclosed relates to service dates beginning:_____and ending: _____			

Purpose of information to be released:					
***Initials of client or guardian needed before information will be released.**					
	Psychiatric/Psychological Information		Drug/alcohol		AIDS/HIV information

Reports to be released:					
Entire medical record	☐	Progress notes	☐	Treatment Plan	☐
Initial assessment (intake)	☐	Narrative summary	☐	Psychological Eval.	☐
Psychosocial history	☐	Comprehensive Psych. Eval.	☐	Lab Reports	☐
Discharge Summary	☐	Medication information	☐	Demographic Information	☐
Other (please specify):					

Form of information to be released:							
Written	☐	Verbal	☐	Both	☐	Faxed *	☐
***Records will only be faxed in the event of medical/psychiatric emergencies to a SECURE FAX.**							

Declining to sign this authorization will NOT affect my ability to obtain treatment, payment, or enroll in a health plan. I understand that this authorization will expire in 365 days (1 year). However, I understand that I have the right to revoke this authorization, in writing, at any time, and that the revocation will be effective except to the extent that Oasis Behavioral Health has already taken action in reliance on my authorization.

***If this authorization has been signed by a legal representative on behalf of an individual, his/her authority to act on behalf of the individual must be described here: _____**

Patient Signature:	Date:
Parent/Guardian Signature:	Date:
Witness Signature:	Date:

STOP!

THIS SECTION IS ONLY TO BE COMPLETED IF YOU WISH TO <u>REVOKE</u> THE ABOVE AUTHORIZATION.

REVOCATION OF AUTHORIZATION	
	I hereby **REVOKE** my permission to release information from my medical record to the person or organization noted on this form.
	I hereby **REVOKE** my authorization for the request for information from the person or organization noted on this form.

Patient Signature:	Date:
Parent/Guardian Signature:	Date:
Witness Signature:	Date: