BEHAVIORAL HEALTH SYSTEMS

Behavioral Healthcare Programs for Business & Industry Since 1989

PATIENT INFORMATION

ABOUT THE PATIENT:

Name (L/F/M): _____
Patient SS#: _____
Home Address: _____
_____
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: _____
_____
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.

Two Metroplex Drive, Suite 500 • Birmingham, AL 35209 • 205-879-1150 • 800-245-1150 • Fax 205-879-1178 • www.behavioralhealthsystems.com