BEHAVIORAL HEALTH SERVICES
AUTHORIZATION TO RELEASE INFORMATION

I, _____ authorize SSM Health Behavioral Health, its agents or employees to disclose my presence in treatment.

In addition, I authorize SSM Health Behavioral Health to provide periodic information about my progress in treatment and a statement summarizing my treatment upon discharge, where applicable.

In addition, I authorize SSM Health Behavioral Health to contact concerned and significant others and talk to them about their participation in SSM Health Behavioral Health Family Programs.

The purpose of this disclosure is to assist in treatment via questionnaires, conferences, telephone calls, visiting, discharge summary, staff recommendations and diagnosis.

I understand that I may revoke this consent at any time and unless an earlier date is specified, it expires upon termination of all SSM Health Behavioral Health treatment.

Release of information according to Federal regulation of "confidentiality" (42CFR Part 2) prohibits any further disclosure without your specific written consent.

I ☐ do ☐ do not authorize family member/significant other to be contacted regarding interventions that may be necessary for harmful or self-destructive behavior (not applicable for outpatients).

If indicated, person to be contacted: _____ Phone: _____

List of all significant person(s):

Name	Effective Date	Patient Initials	Relationship	Information	Visitor	Phone	Telephone #
				☐	☐	☐	
				☐	☐	☐	
				☐	☐	☐	
				☐	☐	☐	
				☐	☐	☐	
				☐	☐	☐	
				☐	☐	☐	
				☐	☐	☐	

_____ Patient's Signature

_____ Parent or Guardian's Signature (If applicable)

_____ Witness

_____ Date

PATIENT LABEL