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Authorization to Release Confidential Records and Information

A. Identifying information about me/the patient

Name: _____ Date of birth: ___/___/

Current phone(s): _____ Social Security #: _____

Name of parent/guardian (if applicable): _____ Phone #: _____

B. Because I believe it is in my/our best interest, I authorize the release of information described below:

FROM: SOURCE		**TO:** RECIPIENT
Person or organization:		Person or organization:
_____		_____
Address: _____		Address: _____
_____		_____
Phone: _____ Fax number: _____		Phone: _____ Fax number: _____
Secure email: _____		Secure email: _____

C. The records to be disclosed are marked by an × in the boxes below. The items *not* to be released have a line ~~drawn~~ through them. All episodes of care are to be included unless page numbers and/or dates are indicated.

Inpatient or outpatient treatment records for physical/medical and/or psychological, psychiatric, or emotional illness

Date(s) of inpatient admission: ___/___/___ to ___/___/___

Date(s) of outpatient treatment: ___/___/___ to ___/___/___

Other identifying information about the service(s) rendered: _____

Social, family, developmental histories

Assessments with diagnoses, prognoses, and recommendations, and all similar documents

Academic or educational records

Information about how the patient's condition affects or has affected his or her ability to complete tasks, activities of daily living, or ability to work

Billing records

Other records: _____

D. I authorize the transfer of these records for the following purpose(s) or uses:

Further mental health evaluation, treatment, or care

Treatment planning ❑ Qualification for services or benefits

Other: _____

E. I authorize the Source named in section B above to share by telephone and/or face to face with the Recipient professional in section B any information that can assist with my/the patient's receiving treatment.

F. I understand the consequences if I refuse to allow this release. My consent is fully voluntary.

G. I understand that the Source of the information has no control of it after it has left the Source's premises.

H. I understand that I may revoke this ROI authorization, but that doing this will not bring back the information that was released before the date of the revocation. I can do this at any time by writing to the Source named in section B. If I do not void or cancel this ROI authorization, it will automatically expire 90 days from the date I signed it.

I. I have had the provisions of this form explained to me and believe that I fully understand this ROI.

J. Signatures:

_____ _____ ____/____/____

Signature of patient Printed name Date

_____ _____

Signature of parent/guardian/representative if needed Printed name

_____ ____/____/____

Relationship Date

Copy for patient or parent/guardian ❑ Copy for Source of records ❑ Copy for Recipient of records