Consent to Release of Information (ROI)
Medical, Mental Health and Substance Use Records

There's hope. There's help.

IPMS2P067

Patient Information

Patient Name:	**Date of Birth:**	**Phone:**
Patient Address:	**Dates of Treatment:** From: To: **Program(s) to Release:**	
Release Information from (facility): Attn: Phone: Fax: Email:	Release Information to (recipient): Address: Attn: Phone: Fax: Email:	

How would you like to receive your information (mail, fax, email):

Information to be RELEASED I understand the information to be released or disclosed may include information relating to substance use, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). I authorize the release or disclosure of this type of information if indicated. **Please select information to be released by entering Yes/No:**

Include Substance Use History/Treatment?		Include Drug/Alcohol Test Results?	
Discharge Order?	Discharge Summary?	Discharge Plan?	Medications?
Psychiatric Eval (CPE)?	History and Physical?	Labs?	Billing?
MD/NP Progress Notes?	Treatment Plan?		
Other Documentation:			

The Purpose of Release:

• Upon presentation to complete a request or pick up records, identification will be requested to ensure validity/authority of the receiving party.

In compliance with the HIPAA Privacy Rule regarding the release of mental health information and the federal confidentiality rules regarding the release of substance use disorder treatment information (42 CFR Part 2), I acknowledge the following:

(1) This consent is subject to revocation at any time, except to the extent that the facility has taken action in reliance on the patient's prior consent. Revocation for mental health records must be provided in writing; revocation of substance use disorder records may be in writing or given verbally.

(2) If not previously revoked, the patient's consent to release mental health and/or substance abuse information will **expire 90 days after the date of this release** unless otherwise noted here: _____

(3) This authorization is in effect until the expiration date, event or condition is met and regardless of whether the patient is still receiving services from the provider.

(4) If requested, the patient is entitled to an accounting of the disclosures of their protected health information.

(5) I understand that my treatment, payment, enrollment, eligibility for benefits will not be conditioned on whether I sign this authorization.

(6) I understand that the PHI used or disclosed pursuant to this authorization may be subject to redisclosure by the person(s) receiving it and no longer protected by the federal Privacy Rules.

_____ _____

Signature Date Name (print) - If not patient, relationship

_____

Witness Date

NOTE TO RECEIVER This information has been disclosed to you from information protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The Federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.