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Authorization for the Release of Protected Health Information (ROI)

Please complete all sections of this HIPAA Authorization Form. If any sections are left blank, this form will be invalid. Use N/A if not applicable.

1. PATIENT INFORMATION

Patient Full Name _____ Date of Birth _____

Street Address _____ *City, State & Zip Code* _____

Phone _____ Email _____

2. I AUTHORIZE

Organization and/or Person Name _____ Phone _____

Practice Street Address _____ *City, State & Zip Code* _____

Email _____ Fax _____

To: ○ Release information to ○ Release information from ○ Exchange information with the person/organization in Section 3.

3. ORGANIZATION/INDIVIDUAL INFORMATION

Organization and/or Person Name _____ Phone _____

Practice Street Address _____ *City, State & Zip Code* _____

Email _____ Fax _____

4. INFORMATION TO BE RELEASED

☐ Specific dates of treatment: _____

☐ **ALL** health information

OR indicate the specific records to be released:

☐ Diagnosis ☐ Psychological evaluation(s) ☐ Discharge summary ☐ Treatment plan ☐ Social history ☐ Provider/hospital records

☐ Medication list(s) ☐ Academic records ☐ Criminal records ☐ Laboratory results ☐ Other: _____

5. PURPOSE OF RELEASE

☐ Coordination of care ☐ Legal purposes ☐ Personal use ☐ School accommodations ☐ Treatment planning ☐ Insurance/benefits

☐ Other: _____

6. EXPIRATION AND REVOCATION

This authorization will expire **one year** from the date signed unless otherwise specified: _____

I understand I may revoke this authorization in writing at any time, except to the extent that action has already been taken.

7. PATIENT & GUARDIAN SIGNATURES

- This authorization is voluntary. I am signing this authorization voluntarily and understand my entitlement to treatment, payment, enrollment, or eligibility for health plan benefits will not be affected if I do not sign this HIPAA Authorization Form.
- Information released may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.
- I have a right to receive a copy of this HIPAA Authorization Form.

* Patients ages 16+ must sign for ROI to be valid.

Patient (Age 16+) Full Name	Patient (Age 16+) Signature	Date

Parent/Guardian Full Name	Parent/Guardian Signature	Date

Relationship of Legal Guardian to patient: _____

Provider Full Name	Provider Signature	Date

Any photocopy of this document shall serve as the original.