RELEASE OF INFORMATION (ROI)

PHONE: (970) 494-4200 • FAX: (970) 493-9889 (MEDICAL RECORDS) • 4102 S. TIMBERLINE RD., FORT COLLINS, CO 80525
www.summitstonehealth.org

Client's Name:	**Client's Date of Birth:**	**Client's MRN:**

I authorize SummitStone to release/receive my information as follows:

Name of Recipient:	**Recipient Organization:**
Recipient Address/Email:	
Recipient Phone/Fax:	**Recipient Relationship to Client:**

The purpose of the disclosure is (please check all that apply):

☐ Client requested letter	☐ Coordination of Care	☐ Communicate therapy results and/or attendance
☐ Obtain/maintain housing	☐ Continuity of Care (ongoing)	☐ Obtain/maintain employment/supported employment
☐ Other (describe):		

I authorize the release of the following information (please check all that apply):

☐ Diagnosis	☐ Attendance Dates/Scheduling	☐ Intake
☐ Medications	☐ Demographics	☐ Treatment Plan(s)
☐ Lab Reports/UABA Results**	☐ Housing/Employment Notes	☐ Discharge Summary
☐ Psychiatric Evaluation	☐ Psychiatric Progress Notes	☐ Therapy Progress Notes*
☐ Other (describe):		

**These notes may contain sensitive health information and may require a meeting with therapist prior to release.*
***UABA results are released to an agency or person by client which means if you have past UABA results in our system, these will be visible. If you DO NOT want past results released, please tell us.*

- I understand that my records and/or those of any individual(s) listed above are protected under federal and state confidentiality regulations. I understand that if I have authorized the release of substance use disorder information that the confidentiality of this information is protected by federal law (HIPAA and 42 CFR Part 2). This information cannot be disclosed or re-disclosed without my written consent, unless otherwise specifically provided for in the regulations. I understand that I may revoke this consent at any time except to the extent SummitStone has already acted in reliance on it. I understand and agree that this release form may be sent to the agencies and persons identified above. Regarding information not pertaining to a substance use disorder, a disclosure authorized by me carries with it the potential for re-disclosure by the recipient and that federal privacy laws may no longer protect that information.
- SummitStone may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this Authorization. I will receive a copy of this Authorization for my records.
- This consent to release information expires two (2) years from date of signature.

_____ _____
Signature of Client, Parent/Guardian (for client under 15 years of age), or Authorized Representative, including authority to act for client. Date of Signature

_____ _____
Signature of Client, Parent/Guardian (for client under 15 years of age), or Authorized Representative, including authority to act for client. Date of Signature

AUTHORIZATION TO REVOKE RELEASE

*By signing below, you are **revoking** permission for SummitStone to release any of the information previously permitted.*

_____ _____
Signature of Client, Parent/Guardian (for client under 15 years of age), or Authorized Representative, including authority to act for client. Date of Signature