Release of Information Form

Please complete this release of information (ROI) form for <u>each</u> person you wish your provider to speak to regarding your care. Please print as many copies of this form as needed to best represent your needs as a client. Purpose of communication includes: planning or continuing appropriate treatment, determining eligibility for benefits, case review, updating files, and other means as specifically requested by the client.

Client's Name: _____ Client's Pronouns: _____

Legal Name *(if different):* _____

My provider is *(select one):*
[] Kayti Protos, DSW, LCSW
[] Tara Ryan-DeDominicis, DSW, LCSW
[] Finn Siepser, MA, MFT (graduate-level student intern)

I authorize my provider to: [] Send [] Receive [] Send and Receive

<u>To / From:</u>

Provider Name: _____ Provider Pronouns: _____ Provider Phone: _____

Provider Email: _____ Provider Fax *(if applicable):* _____

Regarding the following information *(check all that apply):*

[] Medical history & evaluations
[] Mental health diagnosis & evaluation(s)
[] Treatment plan(s)
[] Financial information
[] Emergency contact
[] Treatment summary
[] Progress notes from chart
[] Educational record / academic information
[] Demographic information
[] Other: (please specify) _____
_____

My relationship to the client: [] Self [] Parent/legal guardian [] Personal representative

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individual Identifiable Health Information, parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, chapter 1, part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Signature: _____ Date: _____