



RELEASE OF INFORMATION (ROI)

PHONE: (970) 494-4200 • FAX: (970) 493-9889 (MEDICAL RECORDS) • 4102 S. TIMBERLINE RD., FORT COLLINS, CO 80525
www.summitstone.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 Phone/Fax: Recipient Relationship to Client:
Recipient Address or Email:

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

- Client requested letter
Coordinate of Care
Communicate therapy results and/or Attendance
Judicial or legislative proceeding (if checked NO other purpose can be checked)
Continuity of Care (ongoing)
Obtain/maintain housing and/or employment
Other (please describe):

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

- Attendance Dates/Scheduling
Housing/Employment Notes
Psychiatric Evaluation
Demographics
Intake
Psychiatric Progress Notes
Diagnosis
Lab Reports/UABA Results*
Therapy Progress Notes
Discharge Summary
Medications
Treatment Plan(s)
Monthly Progress Report (may include diagnosis, medications, lab reports/UABA results, attendance dates, note/assessment summary)
Other (please describe):

*If I authorize UABA results to an agency or person, any past UABA results in SummitStone's system may also be included. If I DO NOT want past results released I will tell a member of my care team.

- I understand that my records, or those of anyone I listed, are protected by federal and state privacy laws.
SummitStone may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this Authorization.
This consent to release information expires 2 years from the date of my signature or upon my written withdrawal or revocation of this consent.

By signing below, I agree to the release of my information as outlined above

Signature of Client, Parent/Guardian (for clients under 15, if applicable) or Authorized Representative

Date of Signature

Signature of Client, Parent/Guardian (for clients under 15, if applicable) or Authorized Representative

Date of Signature

AUTHORIZATION TO REVOKE RELEASE

By signing below, I am REVOKING permission for SummitStone to release any of the information previously permitted to be released.

Signature of Client, Parent/Guardian (for client under 15,if applicable), or Authorized Representative

Date of Signature