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
☐ Communicate therapy results and/or Attendance
☐ Continuity of Care (ongoing)
☐ Coordination of Care
☐ Judicial or legislative proceeding (*if checked NO other purpose can be checked*)
☐ 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
☐ Demographics
☐ Diagnosis
☐ Discharge Summary
☐ Housing/Employment Notes
☐ Intake
☐ Lab Reports/UABA Results*
☐ Medications
☐ Psychiatric Evaluation
☐ Psychiatric Progress Notes
☐ Therapy Progress Notes
☐ 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. If I allow the release of substance use disorder information, it is protected by federal law (HIPAA and 42 CFR Part 2). This means it can't be shared again without my written consent, unless the rules say it's okay. I know I can take back my consent at any time, except if SummitStone has already acted on it. I agree that this release form can be sent to the people and agencies listed above. For health information not about substance use, if I allow it to be shared, the person who gets it may share it again, and federal privacy laws might not protect it anymore. For substance use disorder information, if I allow it to be shared, the person who gets it may share it again, but federal privacy laws will still apply.
- 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 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