Erleichda Counseling

Release of Information – ROI

Authorization to Use and Disclose Protected Health Information

Patient Name: _____ **Date of Birth**: _____

Phone Number: _____ Email: _____

Purpose of Request: ☐ Patient Request ☐ Treatment ☐ Legal ☐ Insurance ☐ Other: _____

I **authorize (allow)** Erleichda Counseling (EC) to ☐ **send** ☐ **receive** ☐ **exchange** (check all that apply) my health information to/with/from:

Individual/Provider/Organization: _____

Phone Number: _____

Deliver by: ☐ email: _____ ☐ fax: _____

☐ mail to address: _____ ☐ verbal only

Type of Information: ☐ **All** or: ☐ Primary Care ☐ Mental Health/Psychiatric ☐ Substance Use ☐ Dental

Treatment Dates (if no dates provided, EC will release past 2 years): _____

Type of Health Records:

☐ **Essential Health Records**: Encounter/Progress Notes, Diagnostic Evaluation/Assessment Update, Discharge Summary, Treatment/Service Plan, Laboratory/Pathology/Radiology/Diagnostic Reports

And/Or Specific Records:

☐ Attendance	☐ Encounter/Progress Notes or Visit Notes	☐ Treatment/Service Plan
☐ Billing Records	☐ Immunizations	☐ Entire Designated Record Set
☐ Diagnostic Evaluation/Assessment Update	☐ Lab Results	☐ Problem List
☐ Discharge Summary	☐ Medications	☐ Other: _____

By signing this authorization form, I understand:

- I may **revoke (end)** this authorization at any time, and it must be in writing, but will not have any effect on information released prior to Erleichda Counseling receiving the written notice to end authorization.
- This form will **expire** 2 years from the date signed, if not revoked, or on the following date/event: _____
- Treatment, payment, enrollment, or eligibility for benefits **may not depend** on whether I sign this form unless court ordered.
- **Fees** may be charged for copies of my health records.
- I may **request a copy** of this form at any time.
- If I have authorized release of my health information to someone who is not legally required to keep it private, it **may be re-disclosed** and no longer protected by federal and state law. (42 CFR Part 2, HIPAA, CRS 25.1)
- By signing this form, I **authorize release of my information that may include** sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), family planning/contraception, behavioral or mental health services, and treatment of alcohol or drug use.
- A **copy** is as valid as the original.

I am allowed (have legal authority) to sign on my own or on behalf of the patient; my ability has not been limited/restricted voluntarily or through legal process. I understand Erleichda Counseling may ask for legal documents for verification.

_____ _____

Signature of Patient/Legal Guardian/Personal Representative Date

_____ _____

Print Name, if signing on behalf of patient Relationship to Patient

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