Release of Information Form Completion Instructions

A Release of Information (ROI) gives Comprehensive Life Resources (CLR) permission to send or receive information or talk to people you choose about your services. This allows us to coordinate your care. We will need one Release of Information for each person or organization you authorize us to communicate with.

1. In Section (a), write your First and Last name and then your Date of Birth (D.O.B.) in the appropriate fields. We will add the Client ID if you do not know it.

2. In Section (b), check only one box, telling us what action you want us to take:

   a. The top box means that you want us to make a copy of the records that we have for you here at CLR and release them to the person or provider that you indicate on the ROI.

   b. The middle box will allow CLR to get copies of your behavioral health or other records from your other providers. For example, we would fax your completed ROI to your primary care provider, and they would fax or mail us a copy of your medical or other types of records.

   c. The bottom box will allow us to release and receive information about you only verbally. For example, it will allow us to talk directly or by phone with your family member, a friend or someone else you choose, but no records will be sent.

3. Check each box in Section (c) that indicates records you would like requested or released.

4. In Section (d), check any or all of the boxes if you do not want that type of information included in the ROI. Write the information you do not want released, if you check Other.

5. Section (e) explains when the ROI expires. Read Section (e) for more expiration information. You may revoke or cancel the ROI in writing at any time if there are no legal restrictions.

6. If disclosure of information is for Legal or Other reasons, check one or both boxes in Section (f). If you check "Other" write what that is.

7. Section (g) explains your Health Insurance Portability and Accountability Act (HIPAA) confidentiality rights. Please read them.

8. If you are thirteen years or older, sign and date the form in Section (h). If you are not the client, sign at Section (i). If you are younger than thirteen, someone, who is authorized, must sign for you.

9. Section (i), if you have Power of Attorney, are a Court Appointed Guardian or have other documents that grant you authority to authorize release of information for the client named here, please sign and date this form. Write your relationship to the client. PLEASE NOTE: We will need a copy of documents that grant you authority to release or receive information for CLR to honor the request.

10. Give your completed ROI form to the CLR staff helping you with the form. You may fax the ROI to (253) 396-5810 or mail it to: HIM Department, Comprehensive Life Resources, 1305 Tacoma Avenue So, Suite 201, Tacoma, WA 98402.

Please return to:
Comprehensive Life Resources
c/o HIM Department
1305 Tacoma Ave So. Suite 201
Tacoma, WA 98402
Phone (253) 396-5800
Fax: (253) 396-5810

CLR STAFF USE ONLY

_____

Staff assisting in form completion

☐ ***File only (no action required)***

CONSUMER AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Please allow up to 15 days for processing.

(a) Client ID#: **Client Name:** **D.O.B:**

(b) I hereby authorize Comprehensive Life Resources to:

(Check **one box** only)

☐ **Copy my CLR records and release them to:**

☐ **Request medical, behavioral health, educational, or other type of records from the listed provider and have them sent to CLR.**

☐ **Verbal Exchange Only**

Person/Provider: _____

Relationship to Consumer: _____

Street Address: _____

City, State, Zip: _____

Phone Number: _____

Fax Number: _____

(c) Please check (initials preferred) all records that you would like released to or requested from (including verbal) an outside source:

Behavioral Health

☐ Assessments (12 months)
☐ Psychiatric Assessments (12 months)
☐ Discharge Summary (12 months)
☐ Crisis Plans (12 months)
☐ Prescribing/Medication (12 months)
☐ Other:_____

Medical

☐ EPSDT/Well Child Exam
☐ Admission Information
☐ Discharge Summary
☐ Medication Records
☐ Progress Notes
☐ Other:_____

Education/School

☐ IEP Records
☐ Attendance
☐ Grades
☐ Other: _____

Dental

☐ Office Notes
☐ Other: _____

Substance Use Disorders

☐ Assessment
☐ Treatment Plan
☐ Status Update
☐ Attendance
☐ Other _____
_____

(d) In addition to Behavioral Health information, I specifically authorize the disclosure of information related to the testing, diagnosis and treatment of HIV/AIDS/Sexually Transmitted Disease and Substance Use Treatment.

I have indicated below what I would like excluded:

☐ **HIV/AIDS/Sexually Transmitted Diseases** ☐ **Substance Use Disorders** ☐ **Other**_____

I understand Substance Use treatment records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. parts 160 & 164, and cannot be disclosed without written consent otherwise provided for by the regulations.

(e) Authorization Expiration (45 CFR 164.508c & RCW 70.02.030)

Expiration Date: This authorization will be in effect until ninety days after I am no longer receiving services at CLR.

If I am under Department of Corrections or court order to receive behavioral health services, including substance use disorder treatment, this authorization expires when I am no longer under supervision or required to participate in services.

If I have authorized release of information to a financial institution or employer for purposes other than payment, this authorization will expire automatically one year after the date of signature unless I extend the expiration date or I am no longer in treatment.

(f) **Disclosure of Information** is for continuity of care unless otherwise specified below:

☐ Legal ☐ Other: _____

(g) **HIPAA:** I understand that: 1) I have the right to refuse to sign this authorization and that, if I do not complete and sign the authorization, the information cannot be released; 2) CLR is not allowed to withhold treatment, enrollment, payment or eligibility for benefits if I do not sign this authorization; 3) after the information I have authorized is received by a person or a provider, CLR is no longer responsible for the confidentiality of the released information; 4) I may revoke or cancel this authorization at any time, but I cannot revoke a release that was already completed; 5) I must revoke in writing and submit it to CLR.

(h) Consumer Signature: _____ **Date**: _____

(i) Representative Signature: _____ **Date:** _____

Relationship to Consumer: _____

(Consumer must sign own consent if 13 years old or older)

A copy or FAX of this ROI shall be considered valid in lieu of the original. A fee may be charged for copies of records.