

STEPS TO COMPLETING A RELEASE OF INFORMATION AUTHORIZATION

Hello. Please fill out the attached release of information form and sign/date/time the bottom.

Section 1: Fill out with the patient's information, including previous names.

Section 2: Please check box for the Rogers' facility you are wanting records released from.

Section 3: Please mark if you would like the information Released To and/or Obtained From Rogers. Fill out the facility or provider in which you would like us to be able to communicate with or release records to, as well as the relationship (example: psychiatrist, school, self, parent). If you have more than one provider or multiple facilities you wish to have records released to, please fill out a separate release for each contact.

Section 4: Please check box of what information you are comfortable with us discussing and/or releasing physical copies of. Indicate the dates of service.

Section 5: Substance Use Disorder (SUD) and other sensitive information listed in the authorization will be released. If you do **NOT** want this information released, please check mark the appropriate boxes.

Section 6: Indicate what communication/delivery method(s) you are comfortable with us utilizing to collaborate with the outpatient provider/other requester.

Section 7: Please check mark the purpose for the disclosure. For outpatient providers the typical purposes of disclosure are "continuing care", "obtain collateral information", and "verify compliance with treatment".

Section 8: You have the option to leave this blank. Unless this is filled in, the authorization will expire one year from the date of signature.

Section 9: This is an explanation of your rights with respect to this authorization.

Section 10: Please sign, date and time. If you are signing as the patient's Legal Representative, to the right of your signature, please check the appropriate boxes regarding the patient's status and your relationship to them. If requesting records/information from the RBH-Illinois locations, one witness signature and name is required.

Contact the Rogers Behavioral Health - Health Information Department with questions
1-800-767-4411 and select option "3"

All Sections of the Authorization Must Be Completed

Authorization to Release Protected Health Information

1. Patient Information:

First Name	Middle Initial	Last Name	Former Name(s)	Date of Birth
Street Address		City	State	Zip
Phone Number				

2. I authorize (check all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Rogers Behavioral Health – California | <input type="checkbox"/> Rogers Behavioral Health – Florida | <input type="checkbox"/> Rogers Behavioral Health – Georgia |
| <input type="checkbox"/> Rogers Behavioral Health – Illinois | <input type="checkbox"/> Rogers Behavioral Health – Minnesota | <input type="checkbox"/> Rogers Behavioral Health – Pennsylvania |
| <input type="checkbox"/> Rogers Behavioral Health – Tennessee | <input type="checkbox"/> Rogers Behavioral Health – Washington | <input type="checkbox"/> Rogers Behavioral Health – Wisconsin |

3. To Release To: **To Obtain From:**

Agency/Facility/Person	Relationship	Phone Number	Fax Number
Street Address		City	State
			Zip

4. Information to be Released: Dates of Service: FROM _____ TO _____ Entire Record
If no end date entered, will continue to apply through date of expiration of this authorization Abstract*

<input type="checkbox"/> Psychiatric Evaluation	<input type="checkbox"/> Date of Service Letter	<input type="checkbox"/> Treatment Plans	<input type="checkbox"/> Clinical Summary
<input type="checkbox"/> Medication List	<input type="checkbox"/> Education Planning	<input type="checkbox"/> Discharge Instructions	<input type="checkbox"/> History & Physical/Consult
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Safety Plan	<input type="checkbox"/> Labs	Other: _____

*Abstract=Discharge Summary, Psychiatric Evaluation, History & Physical/Consults, and Medications

5. Type of Information: I understand that the information to be released may include information regarding genetic testing, substance use disorder, HIV test results, and sexually transmitted infections. (check below if you do **not** want this information released):

- Substance Use Disorder Treatment HIV test results and related treatment Sexually transmitted infections Genetic Testing

6. Method of Delivery: (check all that apply)

- US Mail Fax Digital Flash Drive Secure Email: _____ Verbal

7. Purpose of Disclosure: (check all that apply)

- Continuing Care Legal Education Planning Personal Insurance eligibility/payment Verify compliance with treatment
 Other: _____

8. Expiration: This authorization will expire at midnight one year from the date of my signature below unless otherwise designated. Other expiration date, time period, or event: _____ This authorization will apply to health records generated during the time frame specified above up to the date of expiration of the authorization and will include financial information related to this account until the close of the account.

9. Patient Rights Regarding This Authorization:

I authorize the release of the health information described above. By signing this form, I am authorizing the release of all records applicable to this request that are maintained as part of Rogers' health record regarding me. I understand that I may revoke this authorization; I must do so in writing and present the Cancellation of Authorization Form HIM-056 to the Health Information Department. I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the authorization was a condition to obtaining insurance coverage. I understand I may be charged a fee for preparing and delivering the records to fulfill this request. I understand that Rogers may not condition treatment, payment, enrollment, or eligibility for benefits upon execution of this authorization unless the services are being provided solely for the purpose of releasing the information to a third party. I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by the HIPAA Privacy Regulations, but that all recipients of information related to alcohol and drug abuse patient records are informed of the prohibition against disclosure as required by the Confidentiality Regulations found at 42 C.F.R. Part 2. I understand that I have a right to a copy of this authorization and that I have the right to inspect or receive a copy of the material to be disclosed as required under Wisconsin §§ DHS 92.05 and 92.06 and 740ILCS110/4. Per Illinois State Statute 740ILCS110/5, the consent form shall be signed by the person entitled to give consent, and the signature shall be witnessed by a person who can attest to the identity of the person so entitled. I understand that a photocopy/facsimile copy of this document is as valid as the original form.

10. Authorization:

Signature of Patient	Date/Time	Witness #1 Signature/Printed Name & Date: _____
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Witness #2 Signature/Printed Name & Date _____
(If Applicable)

Signature of Legal Representative	Date/Time	If signed by a person other than the patient, patient is: <input type="checkbox"/> a minor <input type="checkbox"/> legally incompetent or incapacitated <input type="checkbox"/> deceased
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Legal Authority: parent legal guardian activated power of attorney for healthcare (If you are signing as a parent of a minor patient, you are declaring that you have not been denied physical placement or parental rights of the child because such placement would endanger the child's physical, mental, or emotional health)

Redisclosure Notice for Recipient of Information: If this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2), 42 CFR part 2 prohibits unauthorized disclosure of these records. For office use: Signature verified: _____ (initials)