Family Care Center
Behavioral Health Services

Release of Information (ROI) Request Form

Patient Information

Patient Name: _____ DOB: _____

Requestor (If different than above): _____ Relationship: _____

Requestor Phone Number: _____

Requestor Email Address: _____
(If applicable, please include a copy of guardian or personal representative appointment order)

Information Requested

1. I hereby request that the Family Care Center provide me with access to my Protected Health Information as checked below for the period of _____ to _____.

Complete Health Record	Minimum Data Set
Activity Documentation	Medication and treatment records
Admission/re-admission Documents	Nursing Documentation
Advance Directives	Progress Notes
Assessments, flowsheets	Reports (Lab, x-ray, other)
Care Plan	Test results
Informed Consent	History, exams, and other records

Other (please describe): _____

2. The information identified above may be used by, or disclosed to, the following individual(s) or organization(s):

Recipient 1.

Name _____

Address _____

Phone Number _____

Fax Number _____

Email _____

Recipient 2.

Name _____

Address _____

Phone Number _____

Fax Number _____

Email _____

3. Purpose of use/disclosure: The information described on the previous page will be used for the following purpose(s):

Initiated at the request of the patient

My personal records

Sharing with other healthcare providers

Other (Describe): _____

4. Please complete the check boxes below indicating how to certain categories of protected information should be handled even if the categories do not necessarily apply to the patient's records.

Check One

I ☐ Do ☐ Do not want information on **Mental Health** to be released.

I ☐ Do ☐ Do not want information on **HIV Tests and Related Information** to be released.

I ☐ Do ☐ Do not want information about **Alcohol and/or Substance Abuse** to be released.

I ☐ Do ☐ Do not want information about **Communicable Diseases** to be released.

Please confirm that you made a selection for each protected information category above. If this form is incomplete, it may not be processed.

5. I would like to receive the requested information in the following format:

Printed Paper Copies: (First 10 pages - $18.53 Pages 11-40 0.85 per page 41+ 0.57 per page)

Pick-up Records ☐ **Mail Records** (Postage charges are applied) ☐

Fax Records to: **Attn:**

Electronic Copy: $5.00 - Electronic copies sent through compatible secure email. ☐

Media: ($1.50 per disk) ☐

Inspection: No Charge. A date, time, and location to view the record will be arranged for you.

If mail or fax is requested, send the requested information to:

Name: _____

Address: _____

City, State, Zip: _____

Fax Number: _____

Authorization Statements/Signatures

1. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and HIPAA may no longer protect the information.

2. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to a Family Care Center staff member. I understand that the revocation will not apply to information that has already been released in response to this authorization.

3. Unless I specify differently, this authorization will expire 12 months from the signature date.

4. I understand that the Family Care Center will not condition the provision of treatment nor payment on the provision of this authorization.

Required Signatures

Signature of Patient:		Date:
Patient Name:		
Signature of Personal Representative: (if applicable):		Date:
Personal Representative Name:		

* If a personal representative executes this authorization, then the authorization must contain a description of the representative's authority to act for the patient (e.g.- "parent" or "guardian ad litem")

Distribution: *Original to patient's Health Record, copy to patient*.

Facility Response

The request for access or copy is: Accepted ☐ Denied ☐

If denied, check the reason for denial:

- ☐PHI is not part of the patient's Designated Record Set
- ☐Federal law forbids making the requested information available to the patient for inspection (e.g., CLIA or Privacy Act of 1974)
- ☐The requested information is psychotherapy notes
- ☐The requested information has been compiled for legal proceeding
- ☐The requested information was obtained under promise of confidentiality and access would be reasonably likely to reveal the source of the information
- ☐The requested information is temporarily unavailable because the individual is a research participant
- ☐Licensed health care provider has determined that access to the requested information would result in physical harm to the individual or others
- ☐Licensed health care provider has determined that the requested information identifies a third person who may be physically, emotionally, or psychologically harmed if access to the information is granted
- ☐Licensed health care provider has determined that access to the requested information by the patient's personal representative could result in harm to the individual
- ☐We are acting under the direction of a correctional institution and letting the inmate access or obtain a copy of the requested information would jeopardize the health, safety, security, custody, or rehabilitation of another person at the correctional institution
- ☐The requested information is not maintained by our Facility

RIGHT TO REVIEW

- ☐Yes
- ☐No (contact the Facility HIPAA Compliance Officer with any questions)

You have the right to file a complaint with the Family Care Center and the Secretary of Health and Human Services, Contact the Facility HIPAA Compliance Officer for additional information.

Completed By:	
Signature of ROI Technician:	
Date:	