SUMMITSTONE HEALTH PARTNERS

Release of Information (ROI)

Phone: (970) 494-4200 • Fax: (970) 493-9889 (medical records) • 525 W. Oak St., Fort Collins, CO 80521
www.summitstonehealth.org

Client Name: _____ Client's Date of Birth: _____

I authorize that the following information may be exchanged between SummitStone Health Partners (SHP) and the following:

Name or Organization Name: _____ Relationship to Client: _____

Address/Email: _____ Phone/Fax: _____

The purpose of the disclosure is:

_____ Client requested letter
_____ Coordination of Care
_____ Communicate therapy results and/or attendance
_____ Obtain/maintain housing
_____ Continuity of Care (ongoing)
_____ Obtain/maintain employment/supported employment
_____ Other (describe): _____

Please check any items below to release the following information:

_____ Diagnosis
_____ Service Attendance Dates/Scheduling
_____ Intake
_____ Medications
_____ Demographics
_____ Treatment Plan(s)
_____ Lab Reports/UA-BA Results
_____ Housing/Employment Notes (circle one)
_____ Discharge Summary
_____ Psychiatric Evaluation
_____ Psychiatric Progress Notes
_____ Therapy Progress Notes*
_____ Other (describe): _____

**These notes may contain sensitive health information and may require a meeting with therapist prior to release.*

- I understand that my records and/or those of any individual(s) listed above are protected under federal and state confidentiality regulations. I understand that if I have authorized the release of substance use disorder information that the confidentiality of this information is protected by federal law (HIPAA and 42 CFR Part 2). This information cannot be disclosed or re-disclosed without my written consent, unless otherwise specifically provided for in the regulations. I understand that I may revoke this consent at any time except to the extent SHP has already acted in reliance on it. I understand and agree that this release form may be sent to the agencies and persons identified above. Regarding information not pertaining to a substance use disorder, a disclosure authorized by me carries with it the potential for re-disclosure by the recipient and that federal privacy laws may no longer protect that information.
- SHP 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 expires two (2) years from date of signature.

_____ _____
Signature of Client, Parent/Guardian (for client under 15 years of age), or Authorized Representative, including authority to act for client.
Date of Signature

_____ _____
Signature of Client, Parent/Guardian (for client under 15 years of age), or Authorized Representative, including authority to act for client.
Date of Signature

Authorization to Revoke Release

By signing below, you are revoking permission for SummitStone to release any of the information previously permitted.

_____ _____
Signature of Client, Parent/Guardian (for client under 15 years of age), or Authorized Representative, including authority to act for client.
Date of Signature