Authorization to Use and Disclose Health/Service Information
Release of Information (ROI) Form

Student

Student Name: ______________________ Birth Date: ______________________

Released By

I authorize:

This/these entity(ies) (name/address of recipient(s)):

Attention: ______________________

Address: ______________________

Phone: ______________________

To use and/or disclose a copy of the health/service information described below for the above named student

Released To

I authorize:

This/these entity(ies) (name/address of recipient(s)):

Attention: ______________________

Address: ______________________

Phone: ______________________

To use and/or disclose a copy of the health/service information described below for the above named student

Purpose

For the purpose(s) of:

☐ This information may be used or disclosed in connection with mental health treatment/services and healthcare operations.

☐ Other purposes (specify each purpose): ______________________

Information to be Disclosed

Description or nature of information to be used and/or disclosed: (check all that apply)

☐ Assessment/Intake Summary ☐ Psychiatric Reports
☐ Service/Treatment Plan ☐ Progress Report
☐ Safety/Crisis Plan ☐ Other records(specify): ______________________

Mental Health ☐Yes ☐No ☐N/A	My records may contain information regarding mental health diagnosis and/or treatment. I give my specific authorization for these records to be released.
Substance Use ☐Yes ☐No ☐N/A	My records may contain information regarding diagnosis and/or treatment for drugs, alcohol use, substance use. I give my specific authorization for these records to be released.

Notices

I understand that, if the recipient of the information disclosed under this authorization is not a health plan or provider covered by federal or state privacy laws, the information may be re-disclosed by the recipient and no longer protected by those laws. If the information being disclosed under this authorization includes HIV/AIDS, sexually transmitted diseases, mental health, genetic testing, and drug/alcohol abuse diagnosis, treatment or referral information, federal law and regulation including 42 CFR Part 2 and 45 CFR Parts 160 and 164 or state law may prevent the recipient from re-disclosing this information. I understand that I may revoke this authorization in writing at any time.

Expiration

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification.
I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Unless sooner revoked, this authorization is valid for 180 days from the signature date below, or for the following time period:

Date: ______________________

Signatures

I have read this authorization, I understand it and I have been offered a copy. A minor patient's signature is required in order to release the following information: (1) HIV/AIDS status, diagnosis, treatment 14 years of age; (2) family planning/abortion no age limit; (3) alcohol/drug treatment 13 years of age; and (4) mental health services 13 years of age.

______________________ ______________________
Signature of student Date

______________________ ______________________ ______________________
Signature of legal/personal representative Relationship to student Date

Update of Authorization Signature 1: ______________________ Date: ______________________
Signature 2: ______________________ Date: ______________________