Authorization for Release / Exchange of Information (ROI)

Primary Care Services | 12801 W Bell Rd, Ste 141-145, Surprise, AZ 85378 | Phone: (623) 401-2882 | Fax: (623) 401-2889 | alliancebhi.com

Patient Information

Patient Name _____

Date of Birth _____

Phone Number _____

Email _____

Authorization Direction

[ ] Release information to [ ] Obtain information from [ ] Exchange information with

Provider/Agency/Person

Name: _____ **Phone:** _____

Address/Fax/Email: _____

Information Authorized for Disclosure

[ ] Primary care records
[ ] Medical history
[ ] Medication list
[ ] Lab results
[ ] Diagnosis
[ ] Treatment plan
[ ] Progress notes
[ ] Psychiatric evaluation
[ ] Psychological testing
[ ] Substance use assessment/treatment records, if applicable
[ ] Billing/insurance information
[ ] Care coordination information
[ ] Legal/court/probation related information
[ ] Discharge summary
[ ] Other: _____

Purpose of Disclosure

[ ] Treatment/care coordination
[ ] Insurance/payment
[ ] Patient request
[ ] Legal/court/probation requirement
[ ] Family/caregiver communication
[ ] Other: _____

Dates of Records

From: _____ To: _____ [ ] All relevant records for this purpose

Expiration

This authorization expires on: _____ If no date/event is listed, this authorization expires one year from the date signed unless a shorter period is required by law or policy.

Acknowledgment and Understanding

- I understand I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it.
- I understand I have the right to receive a copy of this authorization.
- I understand information disclosed under this authorization may be subject to redisclosure by the recipient unless protected by law.
- If this authorization includes substance use disorder records subject to 42 CFR Part 2, additional protections and consent requirements may apply.

Signature

Patient/Legal Guardian Signature **Date**

_____ _____

Relationship/Authority if not Patient **Date**

_____ _____