AXISHealth System

Release of Information – ROI

Authorization to Use and Disclose Protected Health Information

Patient Name		**Date of Birth**	
Phone Number		Email	

- Date of records to be released: ☐ Past 2 years ☐ On/from (date) _____ to (date) _____
- This form automatically expires 2 years from the date signed or when revoked (cancelled), if no date or event is listed.

Identify alternative expiration for this form: ☐ Date or Event _____.

I authorize (allow) Axis Health System to: ☐send ☐receive ☐exchange (check all that apply) my health information to/from/with:

Individual/Organization:	
Phone Number:	
Delivery via:	☐email: _____ ☐verbal only ☐ fax: _____ mail: _____

- Purpose of disclosure: ☐ Patient request ☐ Legal ☐ Insurance ☐ Other: _____
- Type of information: ☐ **All** or: ☐ Primary Care ☐ Mental Health/Psychiatric ☐ Dental ☐ Substance Use Program (Protected by 42 CFR Part 2)
- Type of health records: ☐ **Essential Health Records**: Encounter/Progress Notes, Diagnostic Evaluation/Assessment Update, Discharge Summary, Treatment/Service Plan, Laboratory/Pathology/Radiology/Diagnostic Reports

Or specific records:

☐ Attendance
☐ Billing Records
☐ Diagnostic Evaluation/Assessment Update
☐ Discharge Summary
☐ Encounter/Progress Notes or Visit Notes
☐ Immunizations
☐ Lab Results
☐ Medications
☐ Treatment/Service Plan
☐ Entire Designated Record Set
☐ Problem List
☐ Other: _____

I understand:

- I may revoke (cancel) my consent at any time, by writing to the Health Information Management Department. Revoking (canceling) this form will impact future disclosures of my records; it will not impact records previously disclosed by Axis.
- I am not required to sign this form to receive treatment, payment, enrollment, or eligibility for benefits from Axis. If a court requires disclosure of my records as part of receiving services from Axis, I understand I will be required to complete a separate consent for release to the criminal justice system.
- I may request a copy of this form at any time, and a copy is as valid as the original.
- My records may be redisclosed by the recipient and may no longer be protected by law (HIPAA, 42 CFR Part 2, CRS 25.1).
- Substance use program records protected by 42 CFR Part 2 may not be used or disclosed for civil, criminal, administrative, or legislative proceedings against me without my written consent or a court order.
- Records disclosed under this form may include information related to sexually transmitted diseases (STDs), acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV), behavioral or mental health services, and treatment of alcohol or drug use.
- **By signing below, I affirm I am allowed (have legal authority) to sign on my own or on behalf of the patient. I may be asked for documentation to verify my authority to sign this form.**

_____ _____

Signature of patient/legal guardian/personal representative **Date**

_____ _____

Print name (required if signing on behalf of patient) Relationship to patient (required if signing on behalf of patient)