Foresight

Release of Information (ROI) Form

AUTHORIZATION TO OBTAIN OR DISCLOSE MY PROTECTED HEALTH INFORMATION

Directions: Fill in the appropriate information in each applicable section. A separate authorization must be completed for each request.

Member Full Name:______________________________ Member ID: ____________ Date of Birth: ___________

Email Address: __________________________________ Phone: ________________

Date Records Needed By: _________________________

If both boxes are checked, Foresight staff will release records as specified and send the authorization request to the location listed.

I request and authorize Foresight to: Release To Obtain From **via (choose one)** Fax Mail Email

Name: _______________________________________ Phone: ____________

Address: _______________________________________ Fax: ____________

City: _________________State: _____Zip Code: ____________ Email: ____________________

You may use or disclose the following health information (mark all that apply):

☐Verbal Only ☐Records Only ☐Verbal and Records ☐Appointment Info Only (Date/Time Only; No Reason/Details)

Types of Information to Release:

☐Billing Records ☐Encounter/Progress Notes ☐Psychiatric Evaluation ☐Psychological Testing ☐Progress Notes ☐Sessions Report
☐Treatment Summary ☐Discharge Summary ☐Medication List ☐FMLA, Disability ☐Other_________________
☐All healthcare information in my designated record set (excludes sensitive information requiring specific authorization unless specified below) for the last ___year(s).

I understand that my health record may include information on a diagnosis/treatment related to psychiatric, psychological, or mental conditions, drug and/or alcohol use, sexually transmitted infections (STIs), AIDS, and/or HIV status, and genetic testing.

I consent for the following information to be disclosed: (mark any/all that apply):

☐Drug and/or alcohol use ☐Psychotherapy Notes ☐HIV/AIDS ☐STIs

Reason for Authorization: ☐At individual's request ☐Other:_____________________________

Expiration/Revocation: I understand that I may revoke this authorization at any time by giving written notice to Foresight. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my information have already acted in reliance on this authorization. Without such notice, this authorization expires one year from date of signature, unless specified below:

☐Event (one time release) OR ☐Expiration Date: ____/____/________

The information disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by federal law. State and federal law specifically requires that any patient medical record and/or personal health information containing drug and alcohol diagnosis and treatment, mental health, and sexually transmitted infections, including HIV/AIDS are privileged and confidential and may only be disclosed by express authorization, except as required by law. I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 CFR Part 2 and Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may refuse to sign this authorization. Foresight may not condition treatment, payment, enrollment, or eligibility on the authorization of this release. This Authorization (Agreement) is, and related documents entered into connection with this Agreement are deemed signed when a party's signature is delivered electronically. The signor is executing this Agreement electronically and intends to be bound by the Agreement and agrees that the electronic signature shall be deemed original signatures having the same legal effect as original signatures to the fullest extent permitted by applicable law, including the Federal Electronic Signatures in Global and National Commerce Act, and any similar state law based on the Uniform Electronic Transactions Act, and the parties hereby waive any objection to the contrary. The signor acknowledges that this term is hereby incorporated into the Agreement.

____ _____________________________ __________________

Signature of Member/Legally Responsible Party Relationship to Member Date Signed

A minor's signature alone is necessary and sufficient to release health information related to confidential services the minor legally consented to. The minor's signature below is required for information pertaining to minor confidential services to be released.

____ __________________

Signature of Minor Member Date Signed