Authorization for Release of Information (ROI)

Client name: ____ **VBH ID#**: ___________________
Other names used: _____________________________________ **Date of Birth**: ___________________
Address: ____________________________________ **City/State**: _________________ **Zip**:________
Phone #: ___________________________ **Email**: ____

Authorization to release the protected health information to:

Name: ______________________________________ Phone #: ________________________________

(Contact name is mandatory for nontreatment provider entities)

Agency: _____________________________________ Fax #: __________________________________

Address: ____________________________________ City/State: _________________ Zip:_________

Deliver records by: ☐I will pick up copies ☐Mail ☐Fax ☐Secure Email

This authorization is for: ☐Future use ☐Release now ☐2-way communication only

Purpose of request: ☐Coordination of Care ☐Legal ☐Personal ☐Other (must specify)_________________

Information to be disclosed:

Patient mental health information: ☐Assessment ☐Care Plan ☐Individual Therapy Notes ☐Med Notes ☐Billing records ☐Other (must specify)____

Substance Use Disorder Treatment Records: ☐Assessment ☐Care Plan ☐Individual Therapy Notes ☐Med Notes ☐Billing records ☐Other (must specify)____

Dates of service to be released: ☐All dates ☐Specific date range ______________________________

Expiration of Authorization: If no option is marked, this authorization will expire 1 year from date signed.

☐1-time disclosure ☐Other (must specify event or date) _____________________________________

I understand that:

- I can request a copy of my record. My provider(s) will review my request and the request can be denied if the records are found to be detrimental to myself, my treatment, or others. I can make an appointment with my provider(s) to discuss this decision. Requests can take up to 30 days to complete and charges may apply.
- Medical and mental health records are protected by Federal and State confidentiality laws and regulations and cannot be released without my written consent unless otherwise provided for in those laws and regulations.
- Substance use disorder (SUD) records are protected by 42 CFR Part 2 and cannot be disclosed without my written consent unless otherwise provided for by Federal and State confidentiality laws and regulations.
- This form is voluntary and not required to receive services with Valley Behavioral Health unless the purpose of the treatment is to provide information to the individual/entity identified in this Authorization.
- This authorization may be revoked at any time by completing and submitting a Letter of Revocation. If this authorization is for court-ordered treatment, it cannot be revoked. Revocation will not include any information already shared in reliance upon this authorization.
- Any disclosure of this information has the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules. Valley Behavioral Health does not re-disclose PHI received from third-party providers, entities, and/or agencies except where required by law.

____ _______________

Signature of Client or Personal Representative Date

____ ______________________

Printed Name of Representative Relationship to Client

VBH Medical Records Contact Information: 4460 S Highland Drive, Suite 320, Salt Lake City, UT, 84124; P: 801-273-6425, F: 385-388-8670
Copy given to client: ☐Yes ☐Declined Verified by: ☐License ☐Other ID ☐Known to VBH MRF 2-2020