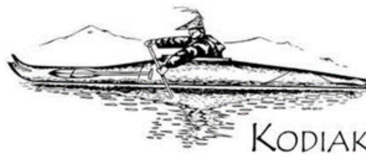


HEALTH SERVICES

Authorization for Release of Information (ROI)

****All information must be completed fully and accurately before health records are released****
Requestor must provide a legible copy of legal identification with this form

Last Name:	First Name:	Middle Name:	Suffix:
Date of Birth:	Contact Number:		
Mailing Address:	City:	State:	Zip Code:

The information is to be disclosed by:		*And provided to:*	
Name of Entity/Facility:		Name of Entity/Facility:	
Mailing Address:		Mailing Address:	
City, State, ZIP:		City, State, ZIP:	
Contact #:	Fax #:	Contact #:	Fax #:
Email:		Email:	

I am requesting the release of this information for the purpose(s) of:

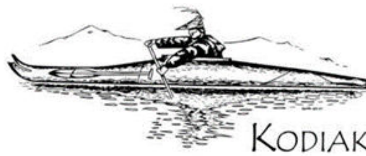
☐ Continuing healthcare ☐ Personal use ☐ Verification of Completion of Treatment
☐ Legal or Administrative proceedings ☐ School ☐ Law Enforcement
☐ Insurance ☐ Disability application ☐ Other________________________________

The information may be transmitted by:

☐ In-Person ☐ Phone ☐ Fax ☐ Mail ☐ Email: ____
(**complete Duty to Warn below)*

*Sending information by email increases privacy risks, as it may increase the risk of accidental disclosure now or in the future. If giving permission to send my information electronically by email, I understand: (INITIAL each)

(____) I have authorized KANA to communicate my protected health information (PHI) by email.
(____) The risks associated with email communication include, but are not limited to, being sent to the wrong email address, or the recipient account being hacked or improperly accessed.
(____) KANA cannot control or ensure the security of my PHI after it is sent via email.
(____) I hold KANA harmless from any liability for sending my PHI by email to the address listed above, including where my PHI is intercepted or inappropriately accessed on the recipient's end.



HEALTH SERVICES

I authorize the following information to be released to or from KANA:

Records from which service(s)?

☐ ALL ☐ Medical ☐ Dental ☐ Mental/Behavioral Health Other:_____________________________________

☐ Only information related to a specific injury, accident, or particular illness:__________________________________
____

From the date of ________________ to ________________ **OR** ☐ From ALL dates of service

What types of Records?

☐ Any/All records	☐ Provider Notes	☐ Test/Assessment Results
☐ Imaging reports	☐ Diagnosis	☐ Immunization Records
☐ Treatment	☐ Medication Lists	☐ Appointments/attendance/completion/discharge
☐ Billing	☐ Other__________________________________	

Please provide additional authorization for the specific release of any information related to the following:

☐ *Substance Use Disorder - Drug/alcohol treatment ☐ Sexually transmitted diseases ☐ Reproductive Health

***Complete ONLY if you would like any of the following Drug/Alcohol information disclosed.**

☐ **ALL** information related to drug/alcohol treatment, diagnosis, or referral for treatment.

☐ Intake Assessment ☐ Treatment Plan ☐ Progress Notes ☐ Medication list ☐ Summary of Attendance

☐ Other____

I understand that information disclosed by this authorization may be subject to re-disclosure and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule (HIPAA) [45 C.F.R. Parts 160 & 164], the Privacy Act of 1974 [5 U.S.C. 522a], or regulations on Confidentiality of Substance Use Disorder Patient Records [42 C.F.R. Part 2].

I understand my substance use disorder (SUD) records are protected under 42 C.F.R. Part 2 and HIPAA, and that they cannot be disclosed without my written consent except as provided for in those regulations. However, if my records are disclosed to another health care provider or other covered entity pursuant to this consent form, I understand that there is a potential for the recipient to use or redisclose those records subject only to HIPAA and not subject to the additional protections of 42 CFR Part 2, with the exception that my SUD records may not be disclosed in connection with civil, criminal, legislative, or administrative proceedings against me, unless with my specific consent or pursuant to a valid court order.

I understand that I may request a copy of this authorization. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment for my eligible benefits.

I understand that this authorization is valid 1 year from the signature date, or upon a minor turning 18 years old. I understand that I have the right to revoke this release of information at any time, <u>except to the extent that KANA has already acted in reliance on it,</u> and that such revocation <u>must be done in writing</u>.

Signature of Patient or Representative: ____ **Date:** _______________________

Print Name of Patient or Representative: _________________________________ **Relationship to Patient:** ____________________

OFFICE USE ONLY

Medical Record Number (MRN): __________________________ Date Copied: _______________ Staff Initials: _______