



**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION**

**INTERNAL USE ONLY**  
Include in EPC Process  
 YES  NO  
Staff Initials: \_\_\_\_\_

|  |  |
|--|--|
| <p><b><u>Client Information</u></b></p> <p>Please print legibly.</p>   | <p>Name*: _____ Date of Birth*: _____</p> <p>Other Names Used: _____ Phone Number: _____</p> <p>Parent/Guardian/Legal Representative Name (where applicable): _____</p>  |
| <p><b><u>Health Care Provider, Person, or Agency</u></b></p> <p>With <b>Whom</b> may The Emily Program and/or its management company, TEP Management Company (collectively, "The Emily Program") share/receive your information?</p> | <p>_____<br/>Clinic/Physician/Provider, Person, Insurer, Person, Agency* (e.g. Dr. John Smith, Children's Hospital)</p> <p>Relationship to client* _____ Phone Number* _____</p> <p>Address (street, city, state, zip code)* _____ Fax Number _____</p> <p><i>*Required Field</i></p>  |
| <p><b><u>Communication</u></b></p> <p>How will The Emily Program share/receive your information?</p> <p>Please check all that apply.</p>   | <p><input type="checkbox"/> Sending/requesting physical copies of your medical record (via mail or fax) to the person identified above</p> <p><input type="checkbox"/> Verbal communication about your care and treatment to the person identified above</p> <p><b>You may choose both options! Confused about the best option to choose? Reference the FAQ.</b></p>   |
| <p><b><u>Information to be Released</u></b></p> <p>What is to be released?</p> <p>Please check all that apply.</p>   | <p><input type="checkbox"/> All records (includes <b>all</b> items listed below)</p> <p><input type="checkbox"/> Intake Evaluations/Diagnostic Assessment <input type="checkbox"/> Individual Therapy Documentation/Progress Notes</p> <p><input type="checkbox"/> Nutritional Documentation <input type="checkbox"/> Substance Use Disorder Records</p> <p><input type="checkbox"/> Medical Documentation/Labs <input type="checkbox"/> Administrative Records (appointments, billing)</p> <p><input type="checkbox"/> Treatment Plans <input type="checkbox"/> HIV/AIDS Records</p> <p><input type="checkbox"/> Discharge Summaries <input type="checkbox"/> Genetic Information</p> <p><input type="checkbox"/> Psychiatry Documentation</p> <p><input type="checkbox"/> Other (please specify) _____</p> |
| <p><b><u>Purpose of the Release of Information</u></b></p> <p>Why is the release needed?</p> <p>Please check all that apply.</p>   | <p><input type="checkbox"/> Coordination of Care <input type="checkbox"/> Disability or Other Benefits</p> <p><input type="checkbox"/> Discharge and Continuation of Care <input type="checkbox"/> Litigation/Legal Purposes</p> <p><input type="checkbox"/> Client Request <input type="checkbox"/> Other (please specify) _____</p>  |

**Statement of Authorization:** I understand that:

- I may revoke this consent at any time, except to the extent that The Emily Program has already acted in reliance on it, by providing oral or written notice to The Emily Program at the address noted in the Notice of Privacy Practices. **After one year, this consent automatically expires.**
- I have been informed what information will be released, its purpose and who will receive the information, and I may inspect or copy the protected health information to be used or disclosed under this authorization per applicable state and federal laws.
- I understand that any substance use disorder treatment and diagnosis records are protected under federal regulation 42 CFR Part 2 and disclosure is allowed only with this specific authorization, except in limited circumstances as stated in The Emily Program's Notice of Privacy Practices and Informed Consent.
- Federal confidentiality regulations (42 CFR Part 2) prohibit re-disclosure of information from substance use disorder records. However, HIPAA requires The Emily Program to notify me that information disclosed pursuant to this authorization might be re-disclosed by the recipient and is no longer protected by HIPAA.
- I understand that I may refuse to sign this authorization. The Emily Program will not condition treatment, payment, enrollment or eligibility for services based on whether I sign this authorization.

**BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND THAT I UNDERSTAND THIS AUTHORIZATION FORM AND AUTHORIZE THE EMILY PROGRAM TO RELEASE THE ABOVE SPECIFIED INFORMATION TO THE PARTY IDENTIFIED ABOVE FOR THE REASON IDENTIFIED ABOVE.**

**Client Signature\***

Parent/Guardian/Representative Signature

**Date\***

Age of Consent for **mental health treatment** by state: Minnesota: 18; 16 for residential. Washington: 13, Ohio: 18; 14 for outpatient, Pennsylvania: 14. Age of consent for **substance abuse treatment** by state: Minnesota: any age; Washington: 13 for outpatient, 18 for residential; Ohio: 18; Pennsylvania: any age.

**Legal Representative (where applicable):** I am legally authorized to represent the client listed above and I understand that I may be asked to provide documentation to demonstrate this legal authority.

# FAQs about Releases of Information (ROI)

## What is a Release of Information Form (ROI) and what is it for?

A Release of Information Form (ROI) documents your consent for The Emily Program to share information about you and your care with your other health care providers such as a primary care doctor or specialist. It also gives your team at The Emily Program permission to communicate with family members and support people.

## Why is an ROI needed?

To comply with federal health care laws and to ensure your privacy, The Emily Program must obtain your consent in writing before communicating with outside persons about you or the services you are receiving at The Emily Program. Filling out an ROI will help your team coordinate care with other professionals you are working with and help us provide you with the most complete and comprehensive care possible.

## Who should I fill out an ROI for?

- Your health insurance company (or third party administrator)
- Any **health care or service providers**, outside of The Emily Program, that are currently participating in your care. It can also be beneficial to allow information to be exchanged with past providers as well. Examples: primary care provider, psychiatrist, other therapists, nutrition counselors, etc.
- Any **support persons** (parents, friends, family, or partners) that you would like to be able to exchange information, work with scheduling, or otherwise support you in your care.
- If you use a **medical transportation** company, a ROI is required for our staff to communicate with drivers, dispatchers, etc.

## What is the difference between the two available communication options?

When you authorize us to share information with the identified person, you have two options as to how The Emily Program should communicate that particular information to the person:

- Sending/requesting physical copies of your medical record (via mail or fax) to the person identified
  - This option allows The Emily Program to send copies of your actual, physical medical record (e.g. lab reports, progress notes, assessments, etc.).
- Verbal communication about your care and treatment to the person identified above
  - This option allows The Emily Program to communicate certain aspects of your care and treatment via verbal communication only. For example, if you allowed us to share updates about your lab reports to your parents via verbal communication, we would share that information verbally over the phone or in person, but not provide a copy of the actual lab report.

For certain people involved in your treatment (e.g. your primary care provider or your parents), it can make the most sense to check both options, which allows The Emily Program to fully communicate and coordinate your care with identified individuals important to you.

## For how long is an ROI valid?

ROIs are valid for one year from the date that they are signed unless you revoke the ROI prior to that date. For continued communication and care, ROIs must be updated annually.

## What if I/we decide not to fill out an ROI?

If you decline to fill out a ROI for your insurer, The Emily Program may not be able to bill the insurer for your services and you will be financially responsible for all services and charges incurred while obtaining at The Emily Program. Electing to not complete an ROI means that all of your treatment information at The Emily Program will remain between you and the providers and staff at The Emily Program.

## How do I know what types of information to consent to release?

If you want The Emily Program to submit claims for reimbursement to your insurance company, we recommend selecting the "all records" option on the ROI. If you are filling out an ROI for the coordination of care between one of your providers at The Emily Program and another health care provider, and are unsure of what information to allow for release, we encourage you to speak with your provider to discuss the best options. Doing so will help answer your questions and ensure that you and your team are on the same page about what information is being shared. The Front Desk at your location is also an excellent resource to answer questions. Or call us at 651-645-5323.

## When is a parent/guardian/representative signature required?

A parent/guardian and/or legal representative must provide consent for release of information for clients unable to consent due to age or judicial determination in accordance with applicable state law.

- **Minnesota:** Parent/guardian consent required if you are admitting to residential and you are under the age of 16. For any other level of care, parent/guardian consent is required if you are under the age of 18.
- **Washington:** Parent/guardian consent is required for any level of care if you are under the age of 13.
- **Ohio:** Parent/guardian consent is required if you are admitting to residential and are under the age of 18. If you are between the ages of 14 and 17 and seeking any treatment other than residential, you may do so without consent of a parent for six therapy sessions or 30 days since first contact with TEP, whichever occurs sooner. Services will be terminated or, with your consent, your parent/guardian will be notified after six therapy sessions are completed or 30 days have elapsed since first contact, whichever occurs sooner.
- **Pennsylvania:** Parent/guardian consent is required if you are under the age of 14 in any level of care.

## What if I don't know the contact information of the other provider that I would like you to release to?

If you don't know contact information for a provider or person you are providing consent for, the Front Desk is happy to help look up information.

## How can I revoke my consent?

ROI's can be revoked before their annual expiration date. To do this, please send a signed and dated letter stating which authorization/with whom you would like to revoke your ROI. Please send this letter to us at: The Emily Program, 2265 Como Ave, St. Paul, MN 55108. Letters that are received will be kept in your chart as record of the revoked.