

Tip Sheet – Release of Information (ROIs)

IMPORTANT NOTE:

Your medical information is protected. An ROI lets us talk to other people (doctors, schools, treatment agencies, etc.) who have taken care of you. We usually ask for information from the last 5 years. The ROI lets us send and receive information to provide better care for you.

ROIs can do up to three things: (usually you want Compass Health to exchange)

- Allow Compass Health to share information about you to someone (such as a caregiver, natural support, family member, or someone involved in your care like your doctor/PCP). This type of action is called **disclose**.
 - Allow someone else (such as a hospital, school, or previous mental health treatment providers) to share information about you with Compass Health. This type of action is called **receive**.
 - Allow Compass Health to send and receive information about you, an exchange of information (such as between Compass Health and your doctor/PCP). This type of action is called **exchange**.
- Key factors to remember:
- ROIs expire when you leave treatment, or if you revoke/end the ROI – Clients can revoke or end an ROI at any time.
 - In an emergency or a situation in which your safety or the safety of someone else is at risk, information about your health or medical records can be released without an ROI.

To complete the ROI form please fill out the required sections:

- Client Name/ID/DOB – Please include the client’s first name, last name, and date of birth in this section.
- Compass Health Address: If you know the name or location you’d like to receive services from please list that here, otherwise leave it blank.

COMPASS HEALTH	
Address:	Everett Child & Family Program
	4526 Federal Ave, Bldg. 9 Everett, WA 98203
Phone:	425-349-8300
Fax:	425-349-8282
Attn:	

- Mark what Compass Health can do: either **disclose**, **receive**, or **exchange** information. List the name of the person Compass Health can talk to about you. This can be a person such as your emergency contact or someone that has helped you in your past such as your PCP, or a hospital, or a school.

Compass Health may Disclose Receive Exchange

the protected health information indicated below with:

Person or Facility: Dr. John Smith PCP

Address: 123 Main St.

Everett, WA 98201

Phone: 425-123-4567

Fax: 425-123-5678

- Please select All Dates. If you do not want to share old information you can add a date range. If you add a date range we will only be able to share information about you from these dates.

I authorize the release of **any and all of the following medical, mental health and/or substance use disorder information, as specified**, which may be contained in my records (Check all that apply) with the following date parameters:

All Dates - or - Date Range:

- Select the types of documents/information you would like to be shared

<input checked="" type="checkbox"/> Behavioral Health Diagnoses <input checked="" type="checkbox"/> Mental Health Assessment <input checked="" type="checkbox"/> Psychiatric Evaluations <input type="checkbox"/> Substance Use Disorder Assessments <input checked="" type="checkbox"/> Treatment/Crisis Plans <input type="checkbox"/> Treatment Plan Reviews <input checked="" type="checkbox"/> Psychiatric Treatment Notes	<input checked="" type="checkbox"/> Progress Notes <input type="checkbox"/> Listing of Services Provided <input type="checkbox"/> Compliance Reports <input checked="" type="checkbox"/> Medication Summary <input type="checkbox"/> Nursing Assessments <input type="checkbox"/> History and Physical <input checked="" type="checkbox"/> Medical Diagnoses	<input type="checkbox"/> Medical History/Profile <input checked="" type="checkbox"/> Lab Results <input type="checkbox"/> Drug Screen Results <input type="checkbox"/> Substance Use Abstinence Status <input type="checkbox"/> Attendance Records <input checked="" type="checkbox"/> Discharge Summary <input type="checkbox"/> Other (specify): <input type="text"/>
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- Indicate at least one reason for disclosure – usually coordinating care/service delivery

Purpose of this Disclosure: (check all that apply)

<input checked="" type="checkbox"/> Assisting in diagnosis and treatment <input checked="" type="checkbox"/> Assuring continuity of care <input checked="" type="checkbox"/> Treatment planning <input checked="" type="checkbox"/> Coordinating care/service delivery <input checked="" type="checkbox"/> Report on progress <input checked="" type="checkbox"/> Referral for other treatment <input checked="" type="checkbox"/> Inform others of treatment status	<input type="checkbox"/> Verify compliance <input type="checkbox"/> Legal Consulting <input type="checkbox"/> Determine disability <input type="checkbox"/> Vocational <input type="checkbox"/> At the request of the individual <input checked="" type="checkbox"/> Educating natural supports about behavioral health issues <input type="checkbox"/> Other (specify): <input type="text"/>
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- To disclose information related to HIV/AIDS or sexually transmitted diseases select the approve box.

I understand that my record may contain information regarding testing, diagnosis, or treatment of HIV/AIDS, or of sexually transmitted diseases. I give my specific authorization for these records to be disclosed. (RCW 70.24.105)	<input checked="" type="checkbox"/> Approve <input type="checkbox"/> Deny
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- Add the date the ROI is effective – usually this would be today’s date.

This Authorization is effective (date):

- Lastly, sign and date the ROI.

<i>Peter Pan</i>	<i>4/10/2020</i>
Signature of client, or client’s parent/guardian/legal representative	Date