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: This area should already be prefilled with the Compass Health's Health Information Management address, but if not, please fill it in with this information:

COMPASS HEALTH
Address: PO Box 3810, M/S 07
Everett, WA 98213
Phone:
Fax:
Attn: Health Information Management

- 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

☒ Behavioral Health Diagnoses	☒ Progress Notes	☐ Medical History/Profile
☒ Mental Health Assessment	☐ Listing of Services Provided	☒ Lab Results
☒ Psychiatric Evaluations	☐ Compliance Reports	☐ Drug Screen Results
☐ Substance Use Disorder Assessments	☒ Medication Summary	☐ Substance Use Abstinence Status
☒ Treatment/Crisis Plans	☐ Nursing Assessments	☐ Attendance Records
☐ Treatment Plan Reviews	☐ History and Physical	☒ Discharge Summary
☒ Psychiatric Treatment Notes	☒ Medical Diagnoses	☐ Other (specify): _____

- Indicate at least one reason for disclosure – usually coordinating care/service delivery

Purpose of this Disclosure: (check all that apply)

☒ Assisting in diagnosis and treatment	☐ Verify compliance
☒ Assuring continuity of care	☐ Legal Consulting
☒ Treatment planning	☐ Determine disability
☒ Coordinating care/service delivery	☐ Vocational
☒ Report on progress	☐ At the request of the individual
☒ Referral for other treatment	☒ Educating natural supports about behavioral health issues
☒ Inform others of treatment status	☐ Other (specify): _____

- 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)	☒ Approve ☐ Deny

- Add the date the ROI is effective – usually this would be today's date.

This Authorization is effective (date): 4/10/2020

- Lastly, sign and date the ROI.

Signature of client, or client's parent/guardian/legal representative Date