AXISHealth System

Release of Information – ROI

Authorization to Use and Disclose Protected Health Information

Patient Name: _____ **Date of Birth**: _____

Phone Number: _____ Email: _____

Purpose of Request: ☐ Patient Request ☐ Treatment ☐ Legal ☐ Insurance ☐ Other: _____

I **authorize (allow)** Axis Health System (AHS) to ☐ **send** ☐ **receive** ☐ **exchange** (check all that apply) my health information to/with/from:

Individual/Provider/Organization: _____

Phone Number: _____

Deliver by: ☐ email: _____ ☐ fax: _____

☐ mail to address: _____ ☐ verbal only

Type of Information: ☐ **All** or: ☐ Primary Care ☐ Mental Health/Psychiatric ☐ Dental ☐ Substance Use Program (Protected by 42 CFR Part 2)

Treatment Dates (if no dates provided, AHS will release past 2 years): _____

Type of Health Records:

☐ **Essential Health Records**: Encounter/Progress Notes, Diagnostic Evaluation/Assessment Update, Discharge Summary, Treatment/Service Plan, Laboratory/Pathology/Radiology/Diagnostic Reports

And/Or Specific Records:

☐ Attendance	☐ Encounter/Progress Notes or Visit Notes	☐ Treatment/Service Plan
☐ Billing Records	☐ Immunizations	☐ Entire Designated Record Set
☐ Diagnostic Evaluation/Assessment Update	☐ Lab Results	☐ Problem List
☐ Discharge Summary	☐ Medications	☐ Other: _____

By signing this authorization form, I understand:

- I may **revoke (end)** this authorization at any time, and it must be in writing, but will not have any effect on information released prior to Axis receiving the written notice to end authorization.
- This form will **expire** 2 years from the date signed, if not revoked, or on the following date/event: _____
- Treatment, payment, enrollment, or eligibility for benefits **may not depend** on whether I sign this form unless court ordered.
- **Fees** may be charged for copies of my health records.
- I may **request a copy** of this form at any time.
- If I have authorized release of my health information to someone who is not legally required to keep it private, it **may be re-disclosed** and no longer protected by federal and state law. (42 CFR Part 2, HIPAA, CRS 25.1)
- By signing this form, I **authorize release of my information that may include** sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), family planning/contraception, behavioral or mental health services, and treatment of alcohol or drug use.
- A **copy** is as valid as the original.

I am allowed (have legal authority) to sign on my own or on behalf of the patient; my ability has not been limited/restricted voluntarily or through legal process. I understand Axis Health System may ask for legal documents for verification.

_____ _____

Signature of Patient/Legal Guardian/Personal Representative | Date

_____ _____

Print Name, if signing on behalf of patient | Relationship to Patient