TIPS FOR FILLING OUT AN ROI: The pink dates should all be the same | Make sure initials are actually initials | The green date should be the date of the client's first ever appointment (e.g., intake, assessment screening)

Client # ________________________

AUTHORIZATION TO RELEASE/EXCHANGE/OBTAIN CONFIDENTIAL INFORMATION

I, **Client name here (AND legal guardian, if for a child client)** hereby authorize the
(printed name of client and authorized agent if signing)

CLINICAL CENTER, SOUTHERN ILLINOIS UNIVERSITY CARBONDALE

to

Client or legal guardian INITIAL on ONE of these lines → ___exchange with ___release to ___obtain from

[Client/agent must initial appropriate space(s) to indicate if information is to be exchanged, released or obtained]

Name of the person/facility to which information will be exchanged, released, or obtained
(Name of Health Care Facility, Physician, Agency, Etc.)

Address, phone number, or fax number for the person/facility above
(Address)

all information contained in the clinical file of **Client's name printed**
(Client)

Client's DOB, relating to services provided to the above named client
(Birth Date)

from **Date that the client's file opened** to **One year from today** for the purpose(s) of:
(Date) (Date)

(1) **Reason (e.g., continuity of care, psychological assessment)**
(2) ____
(e.g., transfer of care, disclosure to attorney, disclosure to insurance company, etc.)

The type of information to be used or disclosed is as follows:

NOTE: The client/agent must initial each checked area for this to be a valid authorization.

Add expiration date and client/legal guardian initial on row for each applicable reason

		EXPIRES month/day/year	Initials
○	Assessment results	____/____/____	____
○	Behavioral observations	____/____/____	____
○	Legal records	____/____/____	____
○	Treatment summary	____/____/____	____
○	Academic records	____/____/____	____
○	Medical records	____/____/____	____
○	Treatment attendance/compliance	____/____/____	____
○	Intervention treatment plan	____/____/____	____
○	Billing	____/____/____	____
○	Scheduling	____/____/____	____
○	Other (please specify) ____________	____/____/____	____

One year from today (→ EXPIRES column)

Client or legal guardian's INITIAL (→ Initials column)

Special Instructions: (e.g. appointment date or pick up date/time/location):
Can say N/A

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Clinical Center. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with a right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: **One year from today**. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.
(Same Date as Expire Date Above)

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact SIU's privacy officer.

SIGNED________________________ DATE________________
Client or authorized representative - Patient 12 years of age or under, Parent or Legal Guardian

If you are not the Client, please specify your relationship to the Client: **e.g., parent, guardian**

WITNESS **Has to be someone that signs when the client/guardian signs** DATE________________

12/19/18