CENTRAL MINNESOTA MENTAL HEALTH CENTER

Instructions on ROI Completion

IMPORTANT: Please read all instructions and information before completing and signing the form. An incomplete form might not be accepted. Please follow the directions carefully. If you have any questions about the release of your health information of this form, please contact the organization you will list in section 3.

This standard form was developed by the Minnesota Department of Health as required by the Minnesota Health Records Act of 2007, Minnesota Statutes, section 144.292, subdivision 8. The form must be accepted by a Minnesota provider as a legally enforceable request under the Minnesota Health Records Act. If completed properly, this form must be accepted by the health care organization(s), specific health care facility(ies), or specific professional(s) identified in section 3.

A fee may be charged for the release of the health information.

The following are instruction for each section. Please type or print as clearly and completely as possible.

1 Include your full and complete name. If you have a suffix after your last name (Sr., Jr., III), please provide it in the "last name" blank with your last name. If you used a previous name(s), please include that information. If you know your medical record or client identification number, please include that information. All these items are used to identify your health information and to make certain that only your information is sent.

2 If there are questions about how this form was filled out, this section gives the organization that will provide the health information permission to speak to the person listed in this section. **Completing this section is optional.**

3 In this section, state who is releasing, exchanging, or sending your health information. **Please be as specific as possible.** If you want to limit what is sent, you can name a specific facility, for example Main Street Clinic. Or name a specific professional, for example chiropractor John Jones. Please use the specific lines. Providing location information may help make your request clearer. Please print "All my health care providers" in this section if you want health information from all of your health care providers to be released.

4 Indicate where you would like the requested health information released, exchanged, or sent. It is best to provide a complete mailing address as not everyone will fax health information. A place has been provided to indicate a deadline for providing the health information. **Providing a date is optional.**

5 Indicate what health information you want sent. If you want to limit the health information that is sent to a particular date(s) or year(s), indicate that on the line provided.

For your protection, it is recommended that you initial instead of check the requested categories of health information.

This helps prevent others from changing your form.
EXAMPLE: All health information

If you select **all health information**, this will include any information about you related to mental health evaluation and treatment, concerns about drug and/or alcohol use, HIV/AIDS testing and treatment, sexually transmitted diseases and genetic information.

Important: There are certain types of health information that require special consent by law. **Chemical dependency program** information comes from a program or provider that specifically assesses and treats alcohol or drug addictions and receives federal funding. This type of health information is different from notes about a conversation with your physician or therapist about alcohol or drug use. To have this type of health information sent, mark or initial on the line at the top of page 2.**Psychotherapy notes** are kept by your psychiatrist, psychologist or other mental health professional in a separate filing system in their office and not with your other health information. **For the release of psychotherapy notes, you must complete a separate form noting only that category. You must also name the professional who will release the psychotherapy notes in section 3.**

6 Health information includes both written and oral information. If you do not want to give permission for person in section 3 to talk with person in section 4 about your health information, you need to indicate that in this section.

7 Please indicate the reason for releasing the health information. If you indicate marketing, please contact the organization in section 4 to determine if payment or compensation is involved. If payment or compensation to the organization is involved, indicate the amount.

8 This consent will expire one year from the date of your signature, unless you indicate a different date or event. Examples of event are: "60 days after I leave the hospital," or "once the health information is sent."

9 Please sign and date this form. If you are a legally authorized representative of the client, please sign, date and include your relationship to the client. You may be asked to provide documents showing that you are a client or the client's legally authorized representative.

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General Authorization for Disclosure of Health Information

◊ File Only/ Do Not Send Records

1. **Client Information**

First Name: _____Middle Name: _____ Last Name (Suffixes):_____

Client Date of Birth: ___ /___ / ____ Previous name(s): _____
MM DD YYYY

Home Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Phone Number: _____ E-mail Address (Optional): _____

2. **Contact information about how this form was filled out (Optional):**

I give permission for the organization(s) listed in Section 3 permission to talk to:

First Name: _____ Last Name: _____ about how this form was completed, this person can be reached at: Daytime Phone: _____ E-mail Address (Optional): _____

3. **I am requesting Health Information be, please circle at least one option:**

1) Released From 2) Exchanged With 3) Sent To

Organization(s) Name: _____ Organization Phone Number: _____

Organization Address: _____

Doctor's Name(s): _____

4. **I am requesting that Health Information be, please circle at least one option:**

1) Released From 2) Exchanged With 3) Sent To

Organization(s) Name: _____

And/or Person: First Name: _____ Last Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone (Optional): _____ Fax (Optional): _____

Information Needed by (Date) (Optional): ___ / ___ / ____
MM DD YYYY

5. **Information to be Released:**

Important: **indicate only the information that you are authorizing to be released.**

___ Specific dates/years of treatment: _____

___ All health information (this will include any information about you related to mental health evaluation and treatment, concerns about drug and/or alcohol use, HIV/AIDS testing and treatment, if you wish to exclude, please see below)

OR to only release specific portions of your health information, indicate the categories to be released:

____ Diagnostic Assessment ____ Treatment Plans

____ Progress/ Medical Notes ____ Billing Records

____ Other (Please Specify): _____

The following information requires special consent by law. Even if you indicate **all health information**, you must specifically request the following information in order for it to be released:
_____ Chemical Dependency Program- Evaluation & Notes (Please complete Chemical Dependency Authorization for Disclosure)
_____ Psychotherapy Notes & Assessments

6. **Health information includes written and oral information**
By indicating any of the categories in section 5, you are giving permission for written information to be released and for a person in section 3 to talk to a person in section 4 about your health information. If you do not want to give your permission for a person in section 3 to talk to a person in section 4 about your information, indicate that here with your initials _____

7. **Reason(s) for Releasing Information:**

_____ Client's Request
_____ Case Consult
_____ Notice of Completion
_____ Outcomes Management Survey
_____ Other (Please Specify): _____

_____ Continuation of care (Ongoing Care)
_____ Litigation/ Legal
_____ Family/ Support Group Contact
_____ Evaluation Collateral

8. I understand that by signing this form, I am requesting that the health information specified in Section 5 be sent to the third party named in section 4.

I may stop this consent at any time by writing to the organization(s), facility(ies) and/or professional(s) named in section 3.

If the organization, facility or professional named in section 3 has already released health information based on my consent, my request to stop will not work for that health information.

I understand that when the health information specified in section 5 is sent to the third party names in section 4, the information could be re-disclosed by the third party that received it and may no longer be protected by federal or state privacy laws.

I understand that if the organization named in section 4 is a health care provider they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form.

If I choose not to sign this form and the organization named in section 4 is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care.

NOTE: I understand that I may be charged a $17.68 retrieval fee plus a copy fee of $1.33 per page in accordance with the MN statute 114.335 Federal Rule 164.524.

9. **Client's Signature:** _____ Date: ____ /____ /_____

OR Legally Authorized Representative's Signature: _____ Date: ____ /____ / _____

Representative's relationship to client (parent, guardian, etc.): _____
(Please attach a copy of the document that gives you authority to act as the legal representative.)

This consent will end one year from the date the form is signed unless I indicate an earlier date or event here:

Date: ____ / ____ / _____ or Specific Event: _____