Client Name: _____

Birthdate: _____

Evolve Treatment Centers

Authorization to Release and/or Receive Confidential Information

_____ authorizes the release of Confidential Protected Health Information as outlined below.

The following information: (Client MUST check each item to be disclosed)

- ☐ Pre-Admissions and Admissions
- ☐ Biopsychosocial Assessments
- ☐ Risk Assessments
- ☐ Nursing Notes
- ☐ MARS
- ☐ Doctor's Orders
- ☐ Vitals
- ☐ E-Lab Results
- ☐ Therapy Homework
- ☐ Treatment Planning
- ☐ Shift Notes
- ☐ Academic / Educational
- ☐ Discharge Plan
- ☐ Insurance / Billing
- ☐ Other:

Parties releasing and/or receiving information:

FROM:

Name of Person or Organization:
Relationship to Client:
Address:
Phone Number:
Fax Number:
Email Address:

TO:

Name of Person or Organization:
Relationship to Client:
Address:
Phone Number:
Fax Number:
Email Address:

* **For the purpose of:**

The disclosure of this information is for the purpose of: .

Within the following timeframe: (Choose by checking your selection)

- ☐ This authorization is valid for 12 months from the date of signature,

OR

- ☐ This consent is valid until this particular date: ,

OR

- ☐ Upon the following event/condition: .

Method of release

☐ Oral, discussion between two people (via phone or in person)

☐ Copy of written records (Choose how you want to receive them below)

A copy of written records should be released in the following specific manner

☐ Physical copy of written records printed and mailed via certified mail (Subject to a standard fee per page)

☐ Electronic copy of written records emailed through encrypted email

☐ Copy of written records faxed to a specific fax number

RIGHT TO REVOCATION

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Evolve Treatment Centers. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization. Send written notification to MedicalRecords@evolvetreatment.com; Fax to (424) 285-8154; or Mail to Compliance Officer at Evolve Treatment Centers at 9301 Wilshire Blvd. Ste. 516, Beverly Hills, CA 90210.

HIPAA

I understand that my records are protected under Federal Confidentiality regulations (42 CFR Part 2). Published August 10. 1987, and the Heath Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. Seq, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that my medical record may contain information concerning my psychiatric, psychological, drug and alcohol abuse, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions. (Under the Mental Heath Code, release of mental health records must be germane to the purpose and need for disclosure).

Signatures Required:

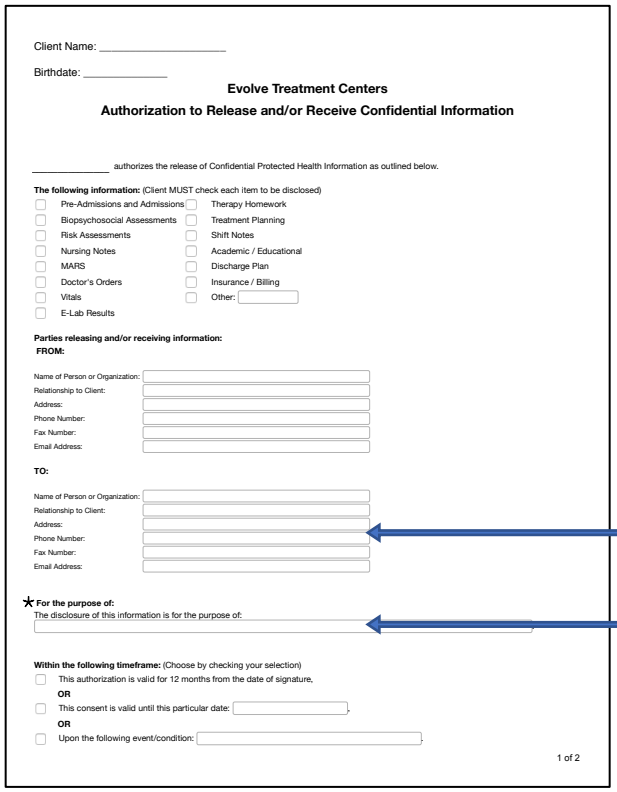
- **Client** (minor or adult) *REQUIRED ON ALL AUTHORIZATIONS*
- **Guardian** (if client is under age 18)

Client Name Printed	Client Signature	Date
Parent or Guardian Name Printed	Parent or Guardian Signature	Date
Parent or Guardian Name Printed	Parent or Guardian Signature	Date
Staff Name Printed	Staff Signature	Date

MEDICAL RECORD REQUESTS

Evolve Medical Records Department

Completing the Release of Information (ROI)



Client Name: _____

Birthdate: _____

Evolve Treatment Centers

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- ☐ Vitals
- ☐ E-Lab Results
- ☐ Therapy Homework
- ☐ Treatment Planning
- ☐ Shift Notes
- ☐ Academic / Educational
- ☐ Discharge Plan
- ☐ Insurance / Billing
- ☐ Other: _____

Parties releasing and/or receiving information:

FROM:

Name of Person or Organization:
Relationship to Client:
Address:
Phone Number:
Fax Number:
Email Address:

TO:

Name of Person or Organization:
Relationship to Client:
Address:
Phone Number:
Fax Number:
Email Address:

★ **For the purpose of:**
The disclosure of this information is for the purpose of: _____

Within the following timeframe: (Choose by checking your selection)

☐ This authorization is valid for 12 months from the date of signature,

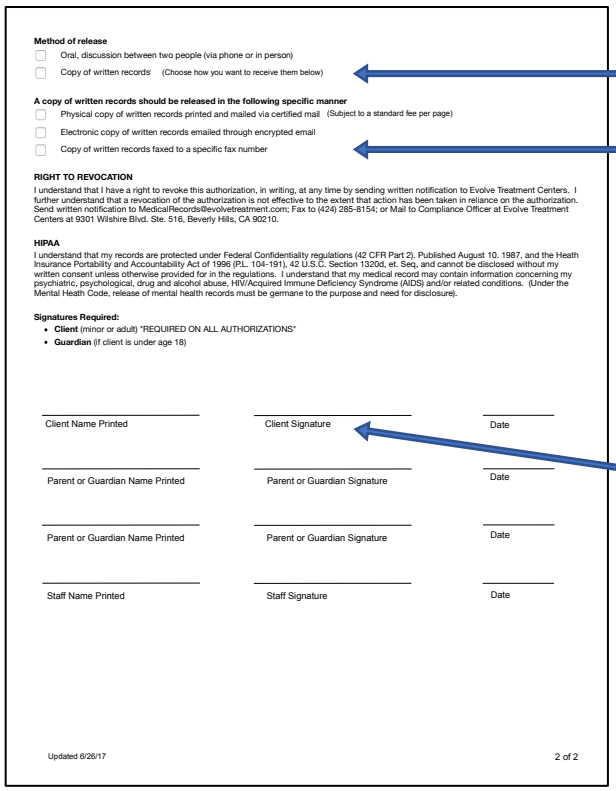
OR

☐ This consent is valid until this particular date: _____.

OR

☐ Upon the following event/condition: _____.

1 of 2



Method of release

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- ☐ Copy of written records (Choose how you want to receive them below)

A copy of written records should be released in the following specific manner

- ☐ Physical copy of written records printed and mailed via certified mail (Subject to a standard fee per page)
- ☐ Electronic copy of written records emailed through encrypted email
- ☐ Copy of written records faxed to a specific fax number

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Client Name Printed	Client Signature	Date
Parent or Guardian Name Printed	Parent or Guardian Signature	Date
Parent or Guardian Name Printed	Parent or Guardian Signature	Date
Staff Name Printed	Staff Signature	Date

Updated 6/26/17

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The ROI must be completed accurately to be valid and therefore for any records to be send. To be valid, the release must have all the following elements (1 - 6) completed correctly.

1. Who will these records be sent to? Be sure that the "TO" section is completed with the contact information for the recipient of the records.

2. Also, be sure to have both a valid fax and email address where the records should be sent.

3. It's really important to describe the reason that the records are needed, and/or what purpose they will be used for. The more specific, the better!

4. One or both can be checked.

5. If "copy of written records" was checked right above it, there must a choice for method of release. Make sure the contact information as where to send the records is provided earlier in the ROI in the "To" section.

6. The client signature must be on each and every ROI. If there are mitigating circumstances, the child is in the hospital, or the parents express extreme concern, please consult the Medical Records Department.

When completed, please send the form to:
Evolve Medical Records Department
Fax: (424) 285-8154 or
Email: MedicalRecords@evolvetreatment.com