evolve
Adolescent Behavioral Health

Release of Information Authorization Form (ROI)

A valid ROI form is required to authorize the release of confidential protected health information.

Client Name: ______________________________ **Birthdate:** ____________________

The following information is being requested

	Consent Forms		Nursing Documentation
	Biopsychosocial Assessment		Doctor's Orders and Prescription List
	Psychiatric Assessment		Daily Medication Log
	Risk Assessments		Daily Vital Signs
	Diagnosis		Drug Screens
	Treatment Plans		Lab Results
	Discharge Documentation		Other:

Party releasing confidential information

Name of person or organization	
Relationship to client	
Address	
Phone number	
Fax number	
Email address	

Party receiving confidential information

Name of person or organization	
Relationship to client	
Address	
Phone number	
Fax number	
Email address	

*Please provide both email address and fax number to ensure that records can be sent efficiently.

Purpose of Disclosure

Timeframe

- ☐ This authorization is valid for 12 months from the date of signature
- ☐ This consent is valid until a particular date ____________________
- ☐ Upon the following event ________________________________

Method of Release

Verbal Exchange

- ☐ Verbal conversation between the two parties listed above

Written Records (choose all that apply)

- ☐ Copy of written records via encrypted email
- ☐ Copy of written records via fax
- ☐ Copy of written records via US mail (subject to a standard fee per page)

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Please note:

- To request billing records, please contact our Billing Department via email at billing@evolvetreatment@com or via phone at (424) 290-3360.
- Session notes are not released per state laws and HIPAA confidentiality practices.

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 300 N. Pacific Coast Highway, Suite 2060, El Segundo, CA 90245.

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 Health Code, release of mental health records must be germane to the purpose and need for disclosure).

Signatures

- The minor client's signature should be included on this release authorization.
- Signatures must be handwritten, an e-signature, or completed through a document signing software, like DocuSign.

Client name printed	Client signature	Date
Parent/Guardian name printed	Parent/Guardian signature	Date
Parent/Guardian name printed	Parent/Guardian signature	Date
Witness name printed	Witness signature	Date

Evolve Adolescent Behavioral Health
Medical Records Department
medicalrecords@evolvetreatment.com
Phone: (424) 502-0803
Fax: (424) 285-8154
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