The Emily Program

# AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

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| **Client Information**<br><br>Please print legibly. | Name*: _____ Date of Birth*:_____<br><br>Other Names Used:_____ Phone Number:_____<br><br>*Parent/Guardian/Legal Representative Name (where applicable):* _____ |
| **Health Care Provider, Person, Agency or Emergency Contact**<br><br>With **Whom** may The Emily Program and/or its management company, TEP Management Company (collectively, "The Emily Program") share/receive your information? | _____<br>Clinic/Physician/Provider, Person, Insurer, Person, Agency* (e.g. Dr. John Smith, Children's Hospital)<br><br>_____ _____<br>Relationship to client* Phone Number*<br><br>_____<br>Address* (street, city, state, zip code) Fax Number<br><br>**Required Field* |
| **Communication**<br><br>**How** will The Emily Program share/receive your information? | ___ Exchange the information indicated below (verbal communication, sending/requesting paper copies of records via mail or fax).<br><br>OR<br><br>___ ONLY Verbally communicating the information as needed for purposes identified below. |
| **Information to be Released**<br>Please check all that apply.<br><br>**What** is to be released? | ___ All Records (including **all** items listed below)<br>___ Intake Evaluations/Diagnostic Assessment ___ Treatment Plans ___ Administrative Records (e.g appointment listings, billing)<br>___ Individual Therapy Documentation/Progress Notes ___ Discharge Summaries<br>___ Nutritional Documentation ___ Psychiatric Documentation ___ HIV/AIDS Records<br>___ Medical Documentation/Labs ___ Substance Use Disorder Records<br><br>___Other (please specify)_____ |
| **Purpose of the Release of Information**<br><br>**Why** is the release needed? | ___ Coordination of Care ___ Insurance<br>___ Discharge and Continuation of Care ___ Litigation/Legal Purposes<br>___ Client Request ___ Other (please specify) _____ |

**Statement of Authorization:** I understand that:

- I may revoke this consent at any time, except to the extent that The Emily Program has already acted in reliance on it, by providing oral or written notice to The Emily Program at the address noted in the Notice of Privacy Practices. **After one year, this consent automatically expires.**
- I have been informed what information will be released, its purpose and who will receive the information, and I may inspect or copy the protected health information to be used or disclosed under this authorization per applicable state and federal laws.
- I understand that any substance use disorder treatment and diagnosis records are protected under federal regulation 42 CFR Part 2 and disclosure is allowed only with this specific authorization, except in limited circumstances as stated in The Emily Program's Notice of Privacy Practices and Informed Consent.
- Federal confidentiality regulations (42 CFR Part 2) prohibit re-disclosure of information from substance use disorder records. However, HIPAA requires The Emily Program to notify me that information disclosed pursuant to this authorization might be re-disclosed by the recipient and is no longer protected by HIPAA.
- I understand that I may refuse to sign this authorization. The Emily Program will not condition treatment, payment, enrollment or eligibility for services based on whether I sign this authorization.

***BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND THAT I UNDERSTAND THIS AUTHORIZATION FORM AND AUTHORIZE THE EMILY PROGRAM TO RELEASE THE ABOVE SPECIFIED INFORMATION TO THE PARTY IDENTIFIED ABOVE FOR THE REASON IDENTIFIED ABOVE.***

_____

**Client Signature*** Parent/Guardian/Representative Signature **Date***

**Age of Consent by state: Minnesota: 18; 16 for residential. Washington: 13, Ohio: 18; 14 for outpatient, Pennsylvania: 14.*
**Age of consent for **substance abuse records** by state: Minnesota: any age; Washington: 12 for outpatient, 18 for residential; Ohio: 18; Pennsylvania: any age.*

**Legal Representative** *(where applicable):* I am legally authorized to represent the client listed above and I understand that I may be asked to provide documentation to demonstrate this legal authority.

_____

Legal Guardian/Representative Signature Relationship to Client/Legal Authority Date

Date Revised: March 31st, 2017

# FAQs about Releases of Information (ROI)

**What is a Release of Information Form (ROI) and what is it for?**

A Release of Information Form (ROI) documents your consent for The Emily Program to share information about you and your care with your other health care providers such as a primary care doctor or specialist. It also gives your team at The Emily Program permission to communicate with family members and support people.

**Why is an ROI needed?**

To comply with federal health care laws and to ensure your privacy, The Emily Program must obtain your consent in writing before communicating with outside persons about you or the services you are receiving at The Emily Program. Filling out an ROI will help your team coordinate care with other professionals you are working with and help us provide you with the most complete and comprehensive care possible.

**Who should I fill out an ROI for?**

- Your health insurance company (or third party administrator)
- Any **health care or service providers**, outside of The Emily Program, that are currently participating in your care. It can also be beneficial to allow information to be exchanged with past providers as well. Examples: primary care provider, psychiatrist, other therapists, nutrition counselors, etc.
- Any **support persons** (parents, friends, family, or partners) that you would like to be able to exchange information, work with scheduling, or otherwise support you in your care.
- If you use a **medical transportation** company, a ROI is required for our staff to communicate with drivers, dispatchers, etc.

**For how long is an ROI valid?**

ROIs are valid for one year from the date that they are signed unless you revoke the ROI prior to that date. For continued communication and care, ROIs must be updated annually.

**What if I/we decide not to fill out an ROI?**

If you decline to fill out a ROI for your insurer, The Emily Program may not be able to bill the insurer for your services and you will be financially responsible for all services and charges incurred while obtaining at The Emily Program. Electing to not complete an ROI means that all of your treatment information at The Emily Program will remain between you and the providers and staff at The Emily Program.

**How do I know what types of information to consent to release?**

If you want The Emily Program to submit claims for reimbursement to your insurance company, we recommend selecting the "all records" option on the ROI. If you are filling out an ROI for the coordination of care between one of your providers at The Emily Program and another health care provider, and are unsure of what information to allow for release, we encourage you to speak with your provider to discuss the best options. Doing so will help answer your questions and ensure that you and your team are on the same page about what information is being shared. The Front Desk at your location is also an excellent resource to answer questions. Or call us at 651-645-5323.

**When is a parent/guardian/representative signature required?**

A parent/guardian and/or legal representative must provide consent for release of information for clients unable to consent due to age or judicial determination in accordance with applicable state law.

- **Minnesota**: parent/guardian consent is required in the following circumstances:
  - When a residential client is under age 16.
  - When a residential client is a minor age 16 or 17 if the client is *not* consenting to treatment and it is determined by an independent examination that the minor is suitable for residential treatment.
  - When an outpatient client is under age 18.
- **Washington**: parent/guardian consent is required in the following circumstances:
  - When a client is under age 13
- **Ohio**: parent/guardian consent is required in the following circumstances:
  - When a residential client is under age 18.
  - When an outpatient client is under age 14.
- **Pennsylvania:** parent/guardian consent is required in the following circumstances:
  - When a client is under age 14
  - When a client is a *non-consenting* minor aged 13-18 whose treatment is consented to by a parent/guardian.

**What if I don't know the contact information of the other provider that I would like you to release to?**

If you don't know contact information for a provider or person you are providing consent for, the Front Desk is happy to help look up information.

**How can I revoke my consent?**

ROI's can be revoked before their annual expiration date. To do this, please send a signed and dated letter stating which authorization/with whom you would like to revoke your ROI. Please send this letter to us at: The Emily Program, 2265 Como Ave, St. Paul, MN 55108. Letters that are received will be kept in your chart as record of the revoked