Clinic Security & Logistics, Inc.
dba

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Instructions for Completing Release of Information (ROI) Authorization to Release Protected Health Information

*Please **DO NOT** use correction fluid/tape as this will invalidate the authorization
**Please place a ~~strikethrough~~ (as shown) *and initial* any mistakes made on the authorization

Fill in the following:

1. The name of the person whose records are to be released.
2. The name of the person whose records are to be released.
3. The social security number of the person whose records are to be released
4. The date of birth of the person whose records are to be released (this is used for verification purposes to ensure we have the correct individual).
5. The current address (House Number/Street Name/PO Box) of the person whose records are to be released.
6. The city, state, and zip code of the person whose records are to be released
7. The name of the person and/or organization you wish to **release or exchange** information to/with.
8. The address of the person and/or organization you wish to **release or exchange** information to/with.
9. The city, state, and zip code of the person and/or organization you wish to **release or exchange** information to/with.
10. The cell phone and/or phone number of the person and/or organization you wish to **release or exchange** information to/with.
11. The fax and/or email of the person and/or organization you wish to **release or exchange** information to/with.
12. Please specify the purpose of the disclosure for obtaining and disclosing records by using the check boxes listed.
13. Please specify the documents that you want released by using the check boxes listed. **We will only release the documents authorized*
14. The name of the person/organization you are releasing to (ie. Legal resource, relative, community resource, etc.) This will be the same name as you listed on line #7.
15. Please provide the date for the day the authorization for release was completed.
16. Please indicate the timeframe that this authorization is valid for and specify the date from the day that you sign the release of information (i.e. If today is 11/4/2020 and I would like

the authorization to be 1 year from the day I sign the authorization, the date will be 11/4/2021).

17. Please provide your signature.
18. Please provide date of signature.
19. If the patient is ***not*** signing the authorization, legal guardian will need to sign and identify the relationship to the client (i.e. parent, guardian). If the patient does not have a legal guardian and is over the age of 18y.o., please mark “N/A” on # 19 and #20
20. Please provide date of signature.
21. Staff signature **PLEASE DO NOT FILL OUT.**
22. Date of signature **PLEASE DO NOT FILL OUT.**
23. **PLEASE DO NOT FILL OUT UNLESS YOU ARE REVOKING YOUR RELEASE.** If you no longer want to exchange information to the person and/or organization identified in the authorization, please provide your signature.
24. **PLEASE DO NOT FILL OUT UNLESS YOU ARE REVOKING YOUR RELEASE.** If you no longer want to exchange information to the person and/or organization identified in the authorization, please provide the date of revocation.
25. The name of the person/organization you are releasing to (ie. Legal resource, relative, community resource, etc.). This will be the same name as you listed on line #7.
26. Please provide the date for the day the authorization for release was completed.