Abide Health Medical APC

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Consent for Release of Information (ROI)

This **Consent for Release of Information (ROI)** form authorizes **Abide Health Medical** (the "Clinic") to disclose **protected health information (PHI)** about the undersigned patient (the "Patient") to a third party as indicated below.

By signing this form, the Patient (or the Patient's authorized representative) provides informed consent for the release of specific health information as described herein.

Patient Information

Patient Name: _____ **Date of Birth:** ___ / ___ / _____

Address: _____

Phone Number: _____ **Email Address (optional):** _____

Purpose of Disclosure

Please check the reason(s) for the requested release of information:

- ☐ **Continuity of Care** (e.g., transfer of records to another provider)
- ☐ **Referral** (e.g., for specialized services)
- ☐ **Insurance/Disability** (e.g., to support a claim)
- ☐ **Legal** (e.g., for court proceedings)
- ☐ **Other (specify):** _____

Information to Be Released

Please specify the information that may be released. The release of information may include, but is not limited to:

- ☐ **Psychiatric/mental health records**
- ☐ **Substance use treatment records** (NOTE: These are protected under **42 CFR Part 2** for confidentiality)
- ☐ **Medical history**
- ☐ **Treatment plans**
- ☐ **Progress notes**
- ☐ **Medication prescriptions and management**
- ☐ **Test results** (e.g., lab, psychological, drug testing)
- ☐ **Other (specify):** _____

Recipient of Information

The following individual(s) or organization(s) may receive the information:

Name of Individual/Organization: _____ **Relationship to Patient (if applicable):** _____

Address: _____

Phone Number: _____ **Fax Number (if applicable):**_____

Email Address (optional): _____

Expiration Date of Authorization

This authorization will remain in effect until:

☐ **Specific expiration date:** ___ / ___ / _____ ☐ **Event upon which it expires:** _____

☐ **Indefinite (until revoked)**

If the Patient does not specify an expiration date or event, the release will remain in effect for **one year** from the date of signing.

Right to Revoke Authorization

The Patient has the right to revoke this authorization at any time. The revocation must be made in writing and submitted to the Clinic. The revocation will be effective only after it is received by the Clinic, and it will not apply to any information already released before the revocation was received.

Potential for Redisclosure

I understand that once my health information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by federal or state confidentiality laws (such as **HIPAA**) or by **42 CFR Part 2** for substance use treatment records. **The Clinic is not responsible for the actions of the recipient after the information is released**.

Acknowledgment of Rights

- I understand that I am not required to sign this form as a condition of treatment, payment, or eligibility for benefits.
- I have the right to inspect and obtain a copy of the information to be disclosed (if not already received).
- I understand that I may ask questions about the information being disclosed, and the Clinic will provide clarification if needed.
- I understand that this consent may include the release of **substance use treatment records** and that such records are protected by federal law (**42 CFR Part 2**).
- I understand that I may request additional specific disclosures in writing.

Patient's Signature

By signing below, I, the Patient (or Authorized Representative), consent to the release of the information as described in this form. I acknowledge that I have read and understood the purpose, scope, and limitations of this consent.

Signature of Patient or Authorized Representative: _____

Printed Name of Patient or Authorized Representative: _____

Relationship to Patient (if applicable): _____ **Date:** ___ / ___ / _____

Special Considerations

- **Substance Use Treatment**: If the information being disclosed pertains to substance use treatment, it is protected by federal **42 CFR Part 2** regulations, and the Clinic cannot release this information without your explicit consent. The Patient must check the appropriate box above to authorize the release of substance use records.
- **Nevada State Law**: Under **Nevada Revised Statutes (NRS 433)**, behavioral health information is also protected, and the Clinic will follow state law regarding the release of mental health records, including additional requirements for disclosures to government entities or courts.

Notice of Privacy Practices The Patient acknowledges receipt of the **Notice of Privacy Practices** from the Clinic, which outlines how their health information is used, disclosed, and protected under **HIPAA** and **Nevada law**.