CENTER for FAMILY DEVELOPMENT

705 W 7th Avenue Suite B
Spokane WA 99202
509-744-1117
cffdspokane.com

Release of Information (ROI) Consent

Client Name: _____ Client DOB: _____/_____/_____

Address: _____

Phone: _____ - _____ - _____ Email: _____

I, _____ (client/guardian), authorize the Center for Family Development and _____ (provider's name) to disclose the PHI as described below.

The Center for Family Development and _____ (providers name) is authorized to disclose/exchange information to/with (Person or Business):

Name: _____

Address: _____

Phone: _____ - _____ - _____ Fax: _____ - _____ - _____

Email: _____

Description of Information to be disclosed:

All health related information with no restrictions
Intake assessment, diagnosis, and treatment plan
Mental health diagnosis
Psychiatric and/or medical diagnosis
Dates of service for payment
Billing
Scheduling and attendance
Developmental and/or social history
Progress notes
Substance Use Disorder
Other: _____

Purpose for disclosed information:

- Coordinate Billing and Payment
- Records Request
- Client Request
- Other: _____
- Coordination of Care
- Continuity of Care
- Legal Matters

This release is valid until:

- Upon Execution
- 90 Days
- One Year (365 Days)
- Date / Event: _____

I understand and acknowledge that:

- I may refuse to sign this authorization and my refusal to sign will not affect my treatment, payment, enrollment, or eligibility for benefits
- I may revoke this authorization at any time in writing, except to the extent that action has been taken based upon this authorization
- The recipient of these records may further disclose this information and it may then no longer be protected by federal privacy regulations
- I am entitled to a copy of this document
- There may be a charge for the release of these records pursuant to 45 CFR 164-524 (4) (HIPAA)
- This authorization shall expire upon my written request to revoke or according to state law
- A copy of this authorization is as valid as the original

☐ By checking this box and signing below I acknowledge that I have read and understood this release of information consent document

Client/Guardian Name (Printed): _____ Date: _____/_____/_____

Signature: _____

Secondary Guardian Name (Printed): _____ Date: _____/_____/_____

Signature: _____