Release of Confidential Records and Information (ROI)

Client Full Name:

Phone:

DOB (MM/DD/YYYY):

Your relationship to the client:

I hereby authorize Convergent Mental Health and Wellness to give/receive information regarding my treatment to/from the following Individual or Organization:

____

Name of Individual/Organization

____

Individual / Organization's Address

____

Phone / Fax Number / Email Address

I give permission for the following information to be given and received:

- Intake and discharge information
- Mental health diagnoses and evaluations
- Clinical treatment summary
- Treatment plan goals (including symptoms)
- Progress notes

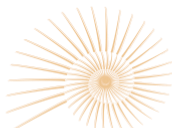
For the purposes of:

- Coordination of care
- Determining eligibility for benefits or program
- Referral to other services
- Billing and payment
- Updating files

I have had explained to me and fully understand this request/authorization to release records and information including the nature of the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent it anytime within 365 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 365 days from the date on which it is signed, or upon fulfillment of the purpose of stated above. I understand my typed signature is equivalent to a written signature.

____ ____

Client / Guardian Signature **Today's Date (MM/DD/YYYY)**



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