centerofbeing.net 505-278-0447 2727 San Pedro Dr. NE Ste 105 ABQ, NM 87110

AUTHORIZATION FOR RELEASE OF INFORMATION (ROI)

Minor Client: I,_____, Parent/Guardian of_____, whose Date of Birth is _____
Parent/Guardian Name Minor Client's Name Minor's DOB

Adult Client (14 yrs or older): I, _____, whose Date of Birth is_____
Name DOB

authorize *Center of Being* to be in contact with: _____, who can be contacted by:
□ phone _____ □ email_____

A. *Center of Being* may DISCLOSE the following information TO this contact (please check all that apply):

___Assessment/Evaluation	___Current Treatment Update	___Billing
___Psychiatric Report	___Progress in Treatment	___Scheduling
___Treatment Plan	___Presence/Participation in Treatment	___Educational Information
___Medication	___Discharge/Transfer Summary	___Medical Information
___Diagnosis	___Toxicological Reports/Drug Screen	___Other _____

B. *Center of Being* may RECEIVE the following information FROM this contact (please check all that apply):

___Assessment/Evaluation	___Current Treatment Update	___Billing
___Psychiatric Report	___Progress in Treatment	___Scheduling
___Treatment Plan	___Presence/Participation in Treatment	___Educational Information
___Medication	___Discharge/Transfer Summary	___Medical Information
___Diagnosis	___Toxicological Reports/Drug Screen	___Other _____

PURPOSE The purpose of this release is to improve service planning, share information relevant to care and, when appropriate, coordinate care services. Other purpose not listed:_____
EXPIRATION This authorization expires at termination of treatment or at the following **date:**_____**.** I understand that I have a right to revoke this authorization, in writing at any time, by sending written notification to *Center of Being*.
CONDITIONS I further understand that *Center of Being* will not make this request for release of information a condition of my care services. It has also been explained to me that choosing to sign this authorization is meant to improve service planning and coordinated care.
FORM OF DISCLOSURE Unless a specific format is requested in writing, *Center of Being* reserves the right to disclose/receive information, as permitted by this authorization, in any format deemed appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically.
AUTHORIZATION FOR RELEASE OF INFORMATION I understand that I have the right to inspect and copy the information to be disclosed. I will be given a copy of this authorization for my records upon request.

Client Name Signature of Client (14yrs or older) Date

Parent/Guardian Name Signature of Parent/Guardian Date