

Instructions
**Authorization to Release Protected Health Information
From Mental Health, Substance Use, and/or Medical Records
C655 (R05) (01/01/20)**

- 1.0 Who: HIMS, Client Services, Clinical, Rehab, and medical staff may assist a patient in completing this release of information (ROI) as appropriate.
- 2.0 When: This form shall be completed anytime a patient wishes to have their protected health information disclosed to another party/entity outside of Bowen Center.
- 3.0 Where: This form shall be used in all outpatient, inpatient, Bowen Recovery Center, and medical clinic locations Center-wide.
- 4.0 Chart Order: This form shall be filed under the Rights/Consents tab in a patient's paper chart. If there is no paper chart, this form will be given to the HIM department for indexing in to the EMR.
- 5.0 Use of Form: The form is used to document the Patient's written authorization to disclose their protected health information to a specific person or organization.
- 6.0 Instructions:
- .1 Print the Patient Name, Date of Birth, Address including City, State, and Zip Code, phone number, and Social Security Number.
- .1 If the patient does not have a social security number and/or refuses to give it out, write "No SSN" in the space.
- .2 Select at least one Bowen Location.
- .1 If they do not select a location, we will not be able to release anything. If they select only one location, we will only be able to disclose information from that one location.
- .3 Specify the name and/or organization the disclosure of information is to be made and the relationship, i.e., mother, principal, employer, attorney, etc.
- .4 Write the address, including city, state, and zip code of the person and/or organization the disclosure of information is being sent to.
- .5 Write the phone number of the person/organization - if known.
- .6 Write the fax number of the person/organization - if known.
- .2 Check the box if for "I authorize the exchange of information from the person / organization listed above to the Bowen Center".
- .1 If box is left unchecked, this means that patient does not authorize us to obtain information from the organization we are releasing information to and they do not want us to reciprocate the exchange of information.

- .3 Indicate the date(s) of treatment/services to be released.
- .4 A Bowen staff member and/or the patient may check box each item authorized to be released.
- .5 A specific purpose(s) for the disclosure of information MUST be checked.
- .6 Document a specific expiration date or expiration at the end of a specific event, i.e., completion of substance abuse treatment program, completion of court-ordered group sessions, etc. The specific event shall be written on the space provided with an approximate time the event will be completed (number of weeks, months).
 - .1 If the patient does not document an expiration date or event, the authorization will automatically expire at 180 days from the date of the signature.
- .7 The patient must sign and date the form.
- .8 If the patient is a minor or unable to sign the form, a personal representative, i.e., parent, POA, guardian, etc. may sign and date the form. The personal representative must include the description of their authority, i.e., mother, father, POA, grandfather, caseworker, etc.
- .9 The person signing the form must print his/her name in the space provided.
- .10 If the person signing the form is not the patient, the "relationship to patient" space must be filled in.
- .11 A witness signature is not required if the form is signed in the presence of a Bowen staff member. A Bowen member *may* witness the patient's signature, but it is not required. However, if the patient does NOT sign the form in the presence of a Bowen staff member (i.e., takes the form home to complete), then a witness MUST authenticate the patient's signature by signing and dating the form as a witness.
- .12 Bowen Center staff and/or the clinician shall check whether the information shall be released immediately or if the release of information shall be filed in the patient's chart for future reference.
- .13 The designated (HIMS) must review the form to ensure that it is valid. Upon validation, he/she shall write the patient's MRN and initial/sign the form indicating it has been reviewed and is valid.

Updated by Sherry Curtis (12/13/19)

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