Sundstrom
CLINICAL SERVICES

Authorization to Release Information - ROI

This document provides the authorization for the release of information and/or the request for information as indicated below. Do not sign this release unless it is completed in full and in your best interests. It is also understood that if the person or organization that receives your information is not a health care provider or health insurer, the information may no longer be protected by federal regulations. You may inspect and/or have a copy of this authorization and the information being released if you request one. **By law, the ROI must be completed by hand.**

☐ SCS Records Release ☐ Records FROM Agency Below ☐ SCS Records to Client

Client Name: _____ Date of Birth: _____

I, the undersigned, hereby authorize (provider's name) _____ and/or Sundstrom Clinical Services, LLC (SCS) to receive information from and/or send information to:

Contact Person/Agency: _____

Address: _____

Phone #: ( ) _____ Fax #: ( ) _____

This authorization for release extends to the care and treatment the client received during: ***Initial one***

_____ All dates of service ____ Service between _____ and _____

This information may be used for the following purpose(s): ***Initial all that apply***

_____ Evaluation, assessment and/or treatment ____ Other: _____

_____ Ongoing coordination of treatment

Below is the information to be released: ***Initial all that apply***

_____ School Transcripts/Records
_____ Treatment Plan or Summary
_____ Psychological Evaluation/Reports
_____ Chemical Dependency Information
_____ Diagnoses
_____ Mental Health Treatment
_____ Test Results
_____ Hospital Discharge Summary
_____ Medical Evaluations
_____ Lab/ X-ray/ Pathology *(only relevant)*
_____ HIV or AIDS information
_____ Psychosocial History
_____ Other:_____

This written consent is subject to revocation by the undersigned at any time, except to the extent that action has been taken in reliance hereon. If not earlier, revoked, or by other agreement specified below, this consent shall expire:

Initial one:

_____ Six months from the date signed
_____ One year from date signed
_____ Therapy Termination
_____ Other:_____

_____ _____
Name of Client, Parent or Legal Guardian **Date**