Release of Information (ROI)

Fillable · A separate form is required for each provider

You may revoke this authorization at any time in writing. Expires 12 months from signing unless specified.

CLIENT INFORMATION

Client Full Name

Date of Birth

Phone Number

PROVIDER TO RELEASE TO / FROM

Provider / Organization Name

Provider Type

Provider Address

City, State, ZIP

Phone Number

Fax Number

DIRECTION OF INFORMATION

- ☐ Branching Streams Psychotherapy, LLC → RELEASE information TO provider above
- ☐ Branching Streams Psychotherapy, LLC ← RECEIVE information FROM provider above
- ☐ BOTH directions

INFORMATION TO BE RELEASED / RECEIVED — check all that apply

- ☐ Psychotherapy notes / treatment summaries
- ☐ Diagnosis and treatment history
- ☐ Medication information
- ☐ Intake and assessment records
- ☐ Psychological testing
- ☐ Substance use treatment records
- ☐ Progress notes
- ☐ Discharge summaries

Other / specify:

PURPOSE OF DISCLOSURE — check all that apply

- ☐ Continuity of care
- ☐ Consultation
- ☐ Legal / court requirement
- ☐ Insurance / billing
- ☐ Personal records request
- ☐ Other

AUTHORIZATION PERIOD

Expiration Date (blank = 12 months from today)

Special Instructions or Limitations

SIGNATURE

I understand I may refuse to sign this authorization without affecting my treatment. I may revoke this at any time in writing except where disclosure has already occurred.

Client / Guardian Signature (type name)

Date

Submit by Email to Robert

Clicking opens your email app — attach completed PDF and send to robert@branching-streams.com