YOUTH RECOVERY CENTER
at Valley View Hospital

Phone: (970)384-7470 **Fax:** (970)945-8491

RELEASE of INFORMATION (ROI)

Client Name:_____ Date: _____

Date of Birth: _____ Social Security Number: _____

I hereby authorize the Youth Recovery Center to communicate with my *Payor Sources(s)* and *Referral Source(s)*, and specifically authorize consultation/release of medical records information in order to facilitate effective treatment, insurance claim processing, and aftercare planning. This information, concerning me, may be exchanged in written and oral form.

Youth Recovery Center
1906 Blake Avenue
Glenwood Springs CO
81601
(970) 384-7470
Fax: (970) 945-8491

Payor's Source(s):
1) **Medicaid ID#**

_____

2) **Insurance Company Name**

_____

Policy/Member ID#

_____

Benefits Phone #:

_____

Medical, clinical, legal and professional agencies or programs:
1)_____
2)_____
3)_____
4)_____
5)_____
6)_____
7)_____
8) _____

Information Requested:

☒ Medical History & Physical	☒ Drug & alcohol history	☐ Legal history
☒ Mental Health history	☒ Immunization records	☐ Insurance Eligibility Information
☒ Social/Family history	☒ Academic transcripts	☐ Other (specify) _____

Information to be sent:

☒ Discharge summaries	☒ Insurance Information	☐ Physical Exam
☐ School report & summary	☐ Payor Source Certification Information	☐ Other(specify) _____

POSSIBILITY OF REDISCLOSURE: I understand that any information released may be subject to re-disclosure and no longer protected by state and federal regulations.

EXPIRATION AND REVOCATION: I understand that this authorization is valid for 13 months following the completion of my treatment. I have the right to revoke this authorization in writing at any time. The revocation will take effect on the day it is received except to the extent it has already been acted upon or if the authorization was obtained as a condition of obtaining insurance coverage.

CONDITIONS OF TREATMENT: I understand that Valley View Hospital or agency cannot withhold treatment upon my signing this authorization unless I am receiving research-related treatment, or the only reason that Valley View Hospital or agency is providing my health care is to make a report to a third party, such as my employer or school.

_____
Signature of Client Date

_____
Signature of Parent, Guardian or Legal Representative Date

_____
Witness Date