ROI Instructions

ROI's must be completed in blue or black pen to be processed. All writing must be legible for records to be released.

All ROI forms must be submitted with a copy of the requesters ID for verification purposes.

There are 2 ROI Forms available:

1. Authorization for Release of Information- General ROI for requesting records.
2. Authorization for Release of Information for Transfers Only- Transfer ROI that is intended only for transferring out of Touchstone.

The Transfer ROI is still the same concept as the General ROI, so you will want to follow the instructions below.

On the top of the ROI, it will ask for the Service Members name and DOB. The Service Members must include both first and last name for the request to be fulfilled. If the Member has a previous last name that they were seen at Touchstone under, you will need to complete a separate ROI form to request the records under the previous name.

If you know the Member's CIS # you are welcome to write it on the form but it is not required. The same goes for the Social Security number.

Person/ Agency Receiving Information:

This section must include the complete name of the person we will be releasing records to. If the person requesting the records is the same person we will be releasing to, we will still need the complete name.

All ROI's must include the complete mailing address in this section for release. We use this for verification and an alternative method of release in case we are unable to fax or email.

If you would like records emailed or faxed, the email address will need to be provided in this section. Please make sure that they are clear and legible for Medical Records to make out.

Records can be picked-up as well. There is a check-box for this option. Records that are being picked-up, will have to be picked up from the Main location at 15648 N 35th Ave, Phoenix, AZ 85053. Once the records are ready you will receive a call to advise that they can be picked-up. Pick- up is in building A, in the Brown Stone buildings at the check-in desk for appointments.

If there is a set way you would like the records to be released, please circle the preferred method of release in this section. We will do are best to accommodate but please be aware that we have fax and email limitations and may not be able to release by these methods. If we are unable to release by fax/email, we would then mail the records out or prepare for pick-up if the option is checked off on the ROI form.

Size limitations for each method of delivery are as follows below:

- If records request contains 50 pages or more, records will be burned onto disc.

- If records request is smaller than 50 pages, records will be printed out.
- If records request is smaller than 50 pages, records can be faxed.
- If records request is smaller than 70 pages, records can be emailed (Through secure email).

All Records that are being picked-up, will have to be picked up at the address below in building A. The records will be stored at the appointment check-in desk and you will need to bring your picture ID for verification to sign the records out.

Touchstone Health Services
15648 North 35th Avenue
Phoenix, AZ 85053

Under Information to be disclosed, check all that apply:

On the Transfer ROI you will need to check all the items off in the "Information to be disclosed" section. These notes are required for transferring out.

This section will need to be completed so Medical Records will know which notes you are requesting. Below is a breakdown of what each option is. If you are still unsure which one to check off, please feel free to use the "Other" option and write which notes you are looking. The "Other" option is also to be used if you are requesting program specific notes (IECP, FCAP, WIT, HNCM, IOP).

Diagnosis/ Prognosis: Includes Psychiatric Med Notes, or if there is not any of Psych. Notes available then the Intake/ Annual Assessments would be used in place.

Oral Communication: This is to allow communication between the staff and the person/ agency records are being released to. This will help if the requestor has any questions regarding the records.

Psychiatric Assessments/ Evaluations: This includes the Psychiatric Assessment and Evaluations only.

Treatment/ Service Plans: CFT's, Service Plans and Therapy Treatment Plans.

Intake Assessment/ Annual Assessments: Assessment completed at time of Intake and Annual Assessment updated from that Initial Intake Assessment.

Payment Records: This option is only for Itemized Billing Statements.

Case Management: Case Management, Billable and Non- Billable notes.

Progress Notes: Med Monitoring Notes, Dr. Consults, Psych Assessments/ Evaluations.

Medical: Med Monitoring Notes, Dr. Consults, Psych Assessments/ Evaluations.

Discharge/ Disenrollment Summary: Discharge Summaries from specific services and Disenrollment note once services are closed out.

Test Results/ Labs- Results of labs.

Psychotherapy Notes: Therapy Notes: Family Therapy, Individual Therapy, Sand Tray Therapy, Group Therapy, Program Specific Therapy Notes (WIT, IECP, HNCM, IOP, FCAP, etc.). If you would like a copy of

any of the notes in the specific programs, you will need to use the "**Other**" line to specify which program notes are being requested.

Purpose of Disclosure: You may use this space to provide the reason you are requesting the records.

On the Transfer ROI: Please include the reason you are requesting to transfer s that this information can be provided to the new agency.

ROI's can be used for extended release for up to a year, if there are no changes. If you would like to use this option, you will need to complete the section that states, "I revoke this authorization" and either use the date that is 1 year from the date you are signing the ROI form or you may check off one of the other options listed in this section.

The last section of the ROI is the Signature and Date of Signature. The legal guardian will need to complete this section if the Member is under 18 years old. If the Member is 18 or older, they will need to sign and request the records.

If the requestor has POA of the adult Member then they would sign but we would also need a copy of the POA submitted with the ROI form and picture ID. If there is any legal documentation regarding custody, you would want to submit that with the ROI as well.

Once the ROI form is completed, you will need to either make a copy of your picture ID. The ROI and ID can be submitted any 1 of the 3 ways listed below:

1. Email: Email to MedicalRecords@touchstonebh.org
2. Fax: Fax to 602.732.5463
3. Drop off: Drop off to any Touchstone location

Please allow 7 to 10 business days to process medical records request. In the event, you have an urgent medical records request, please note this on the ROI form and we will do our best to accommodate.

For ROI's that are submitted for Transferring agencies, we ask that you allow us 30 days to process these. There are further steps that will be needed to process a transfer so they generally take longer to process.

If there are any questions regarding the ROI form, please feel free to contact our Medical Records Specialist, Andrea Fushek at 602.908.6027 or by email at MedicalRecords@touchstonebh.org.

AUTHORIZATION FOR RELEASE OF INFORMATION

* ______________	______________	______________	* ______________
Member's Name	**CIS #**	**AHCCCS #**	**Date of Birth**

Person/Agency authorized to make the disclosure: **Touchstone Health Services**
15648 North 35th Avenue, Phoenix, AZ 85053

Person/Agency Receiving the Information:

***Name:** ______________________________ **Phone #:**____________________

***Address:**____

E-mail: ______________________________ **Fax #:**____________________

***Please number 1 to 4 for preferred Methods of Release: Pick Up:______Mail:______Fax:_____E-Mail:_____**

****Please note if records are too large to e-mail or fax, records will be mailed in place.**

***Information to be disclosed, check all that apply:**

__ Diagnosis/Prognosis	**__ Psychotherapy Notes**	**__ Discharge/Disenrollment Summary**
__ Oral Communication	**__ Case Management**	**__ Test Results/Labs**
__ Psychiatric Assessments/Evaluations	**__ Progress Notes**	**__ Other (Specify Below**
__ Treatment/Service Plans	**__ Medical**	
__ Intake Assessment/Annual Assessments	**__COC (Coordination of Care)/ Oral Communication**	

Other Information to Include:____

***Dates of Records: From:** ______________ **to:** ______________**OR, if no dates, 2 years will be released.**

*__ Check here if each of the above parties may disclose your information with the other party. The above information may include records of drug abuse, alcoholism, sickle cell anemia, human immunodeficiency virus (HIV).

***Purpose for Disclosure:**____

I understand I may revoke this authorization at any time by writing to the RHBA or marking and signing the appropriate box in the original signed copy of this form located in my medical record. The revocation will be effective except to the extent that action based on this authorization has already been taken. The RBHA may not condition treatment, payment, enrollment or eligibility for benefits on whether the consumer signs the authorization. The information used or disclosed by this authorization may be at risk for re-disclosure by the recipient and no longer protected by federal privacy laws.

***This consent will expire 1 Year from the date of Signature:**____________________ **(Initial Here)**

OR: I revoke this authorization ON: Date:________________**Initial Here:**________________

* ______________________________ * ______________________________
Signature of Service Member/Guardian **Date of Signature**

______________________________ ______________________________
Other required signature (if applicable) **Staff Member Reviewing & Submitting ROI**

* ______________________________
Relationship to Service Member

***If a consumer is between 12-18 years of age, both his/her signature is preferred along with the required signature of parent/legal guardian.**

Notice: Alcohol and drug abuse patient records are protected by Federal confidentiality regulations (42 CFR part 2). The Federal regulations prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release medical or other information is NOT sufficient for this purpose. The Federal regulations restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Communicable disease related information, pursuant to this release, cannot be redisclosed without specific authorization. (A.R.S. 36-664.H)

AUTHORIZATION FOR RELEASE OF INFORMATION FOR TRANSFERS ONLY

________________________ ____________ ______________ ____________

Member's Name **CIS #** **SS#** **Date of Birth**

Person/Agency authorized to make the disclosure: **Touchstone Health Services**
15648 North 35th Avenue, Phoenix, AZ 85053

Agency Receiving the Information:

Agency Name: ____ **Phone #:**______________________

Address:____

E-mail: ____ **Fax #:**____________________________

Information to be disclosed:

__ **Intake Assessment/ Annual Assessment** __ **Psych. Progress Notes** __ **SCND** __ **Demographics**
__ **CFT/ Service Plans** __ **Psychotherapy Notes** __ **Crisis Plan** __ **Test Results/Labs**
__ **Psychiatric Assessments/Evaluations** __ **Medication List** __ **CASII** __ **Coordination of Care**

Other: ____

Dates of Records: From: ___Intake_________________ **to:** ____Disenrollment______

__ Check here if each of the above parties may disclose your information with the other party. The above information may include records of drug abuse, alcoholism, sickle cell anemia, human immunodeficiency virus (HIV)

Purpose for Disclosure: Transfer: Reason for Transfer Request:____

I understand I may revoke this authorization at any time by writing to the RHBA or marking and signing the appropriate box in the original signed copy of this form located in my medical record. The revocation will be effective except to the extent that action based on this authorization has already been taken. The RBHA may not condition treatment, payment, enrollment or eligibility for benefits on whether the consumer signs the authorization. The information used or disclosed by this authorization may be at risk for re-disclosure by the recipient and no longer protected by federal privacy laws.

I understand this consent will expire after Transfer is complete: Initial:______________________________

____________________________________ ______________________________

Signature of Service Member/Guardian **Date of Signature**

____________________________________ ______________________________

Other required signature (if applicable) **Staff Member Reviewing & Submitting ROI**

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Relationship to Service Member

***If a consumer is between 12-18 years of age, both his/her signature is preferred along with the required signature of parent/legal guardian.**

Notice: Alcohol and drug abuse patient records are protected by Federal confidentiality regulations (42 CFR part 2). The Federal regulations prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release medical or other information is NOT sufficient for this purpose. The Federal regulations restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Communicable disease related information, pursuant to this release, cannot be redisclosed without specific authorization. (A.R.S. 36-664.H)