touchstone health services
partnering with families

AUTHORIZATION FOR RELEASE OF INFORMATION FOR TRANSFERS ONLY
PLEASE PRINT CLEARLY AND COMPLETE ALL FIELDS

Member's Name	CIS #	AHCCCS ID #	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
- ☐ CFT/ Service Plans
- ☐ Psychiatric Assessments/Evaluations
- ☐ Psych. Progress Notes
- ☐ Integrated Care
- ☐ Medication List
- ☐ SCND
- ☐ Crisis Plan
- ☐ CASII
- ☐ Demographics
- ☐ Test Results/Labs
- ☐ Coordination of Care

Other: _____

Dates of Records: From: Intake **to:** Disenrollment

Member Receives Services from Other Agencies? If Yes, Contact Information (Name/Phone/Email):

_____

☐ 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 agency 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 agency 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**

_____
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)