



CF-11.0

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Reviewed: 1-15-2026

NAME: _____
Last First MI
ID/#: _____ DOB: _____
GENDER IDENTITY: _____ SEX: _____

DISCLOSURE OF INFORMATION AUTHORIZATION

(Also known as ROI)

Facility/ Entity Disclosing the Information:

Name: _____
Address: _____
Phone#: _____ Fax#: _____

Facility/ Entity Receiving the Information

Name: _____
Address: _____
Phone#: _____ Fax#: _____

CONSENT

I hereby give consent to disclose the following information to the facility/entity listed above.

- | | | | |
|--|---|--|---|
| ☐ Records related to treatment of _____ Dates From _____ To _____ | | | |
| ☐ Physician/Provider's summary of my diagnosis, medication, treatments, prognosis, and recent care. | | | |
| ☐ Admission Reports | ☐ Attendance | ☐ Treatment | ☐ Reports |
| ☐ Discharge | ☐ Diagnosis | ☐ Progress/Summary | ☐ Special Studies |
| ☐ Summary/Reports | ☐ Medications | ☐ Progress Notes | ☐ Imaging Reports |
| ☐ Mental Health Reports | ☐ Psychiatric Evaluation | ☐ Summary Reports | ☐ Immunization History |
| ☐ Assessment Information | ☐ Treatment Plan | ☐ Psychiatric Summary | ☐ Other: _____ |

Initials Per the HIPAA Privacy Rule §164.508(c), I understand that once disclosures of the above records have been made, the information may be re-disclosed by the recipient and are no longer protected by federal privacy regulations.

Initials Substance Abuse Treatment History and Counseling Records – Dates: From: _____ To: _____
Per 42CFR Part 2 regulations, I understand that my substance abuse treatment history and counseling records may only be disclosed to the above noted facility and **that any re-disclosure by that facility is strictly forbidden without my specific consent.**

Purpose of Disclosure: ☐ Continuity of care ☐ At my request ☐ Other: _____

I understand that I may revoke this authorization in writing at any time except for any previous disclosures made based upon it.

This authorization expires on this date: _____ OR, upon this event or condition: _____

*If no date or other event is specified, this authorization will expire after one year from today's date.

I sign this willingly, and I release VitalCore Health Strategies, (provider) _____, and the facility from any liability which may result from this disclosure of information.

Patient/Guardian: _____
Name Signature Date Time

Witness: _____
Name Credentials Signature Date Time

REFUSAL

I refuse to share my private Health Care Information at this time. I understand that I may change my mind at any time by notifying Health Services. I assume the risks and consequences of not sharing my health information and release the Health Care Provider, VitalCore Health Strategies, the Facility, and their agents and employees from any liability. The provider will not condition any treatment on my signing of this authorization.

Patient/Guardian: _____
Name Signature Date Time

Witness: _____
Name Credentials Signature Date Time

A witness signature is only required if the Patient is unwilling to sign the consent form or an impairment is identified.

Write "Pt declined or is unable to sign" on the Patient signature line.

Patients with Guardianship or Durable Power of Attorney (DPOA) papers cannot sign consent. The Guardianship or DPOA papers must be in the chart.