

# AVAILIA<sup>TM</sup>

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316 West Boone Avenue - Suite 669 - Spokane, Washington 99201

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## Release of Information (ROI):

**Client Name:** \_\_\_\_\_ **Client DOB:** \_\_\_\_\_

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I, the above-named, hereby authorize AVAILIA TELEHELP PLLC

**& (Agency &/or Department):** \_\_\_\_\_,

attention/care of **(Specific Contact Name):** \_\_\_\_\_

**at:** Email: \_\_\_\_\_, Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_, Fax: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

City: \_\_\_\_\_, State: \_\_\_\_\_, Zip: \_\_\_\_\_

to engage in the mutual exchange, release, and confirmation of my personal, clinical, and/or otherwise confidential information, using any reasonable and secure method. I understand the purpose of this disclosure can include service coordination, compliance reporting, and other uses allowed by law. Information may include service details, progress notes, clinical information, attendance, completion/discharge, urinalysis results and compliance details.

I understand services may be provided via secure 'telehealth' or SVC (synchronous video conferencing). I consent to telehealth and understand the risks, benefits, and alternatives.

**Client Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Availia TeleHelp PLLC & signee agree that any digital signature may serve the full legal effect & function.

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**Staff Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Completing this form authorizes the exchange of information as structured by law, including HIPAA (45 CFR 160 & 164), 42 CFR Part 2, 49 CFR Part 40, and Washington law (RCW 70.02, 26.44, 74.34). Third-party disclosure is prohibited unless allowed by law, and unauthorized re-disclosure may result in penalties. This authorization may be revoked in writing to the extent allowed by law, except where action has already been taken in reliance on it. Unless revoked earlier in writing, it remains valid through service completion and required reporting, and for twelve months after final closure in-case of any related follow-up. ROI updated 1/29/26.