



KNO'QOTI
NATIVE WELLNESS, INC.

809 S. Main Street, Lakeport, CA. 95453
Phone: (707) 900-2121 Website: knwi.org

RELEASE OF INFORMATION (ROI) AUTHORIZATION FORM

RELATIVES (CLIENT) INFORMATION

_____	_____	_____
First Name	Middle Name	Last Name
_____	_____	_____
Date of Birth	Phone	Email

Address		
_____	_____	_____
City	State	Zip code

PURPOSE OF THIS AUTHORIZATION

I authorize Kno'Qoti Native Wellness, Inc. (KNWI) to exchange information as needed to assist with my care, services, program enrollment, case management, coordination of care, and overall wellness support.

RELEASED INFORMATION

I authorize KNWI to receive, share, or discuss the following information (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Healthcare Records | <input type="checkbox"/> Case management |
| <input type="checkbox"/> Behavioral or mental health information | <input type="checkbox"/> Program enrollment or participation details |
| <input type="checkbox"/> Substance use treatment information
(42 CFR Part 2 Protected) | <input type="checkbox"/> Social Services or benefits information |
| <input type="checkbox"/> Other (describe): _____ | |

PARTIES AUTHORIZED TO EXCHANGE INFORMATION

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |

METHOD OF COMMUNICATION

- In person
- Email
- Fax
- Other: _____
- Phone
- Text message
- Written documents

EXPIRATION OF THIS AUTHORIZATION

This authorization expires on:

- One year from the date of signature
- On this date: _____
- When services with KNWI end.

MY RIGHTS

- I understand I may refuse to sign this form.
- I may cancel this authorization at any time by giving KNWI written notice.
- Canceling this authorization does not apply to information already released.
- KNWI will not condition service on signing this unless allowed by law.
- Information shared may be subject to redisclosure by the receiving party unless protected by federal or state law.

CLIENT SIGNATURE

_____	_____
Client Signature	Date
_____	_____
Parent/Guardian Signature (if applicable)	Relationship to Client

Date	

THIS SECTION FOR KNWI STAFF ONLY	
_____	_____
KNWI Staff Receiving Authorization	Date