Counseling&Recovery SERVICES OF OKLAHOMA
Certified Sanctuary Community

Client ID_____

Consent for Release of Confidential or Protected Health Information

Name of Client, printed	Telephone	Date of Birth	Last 4 #s of SS#

Authorize: Counseling and Recovery Services
7010 S. Yale Ave., Suite 215
Tulsa, OK 74136
Ph: 918-492-2554
Fax: 918-499-1598

To Release To And/Or Obtain From

_____
Name of Person & Facility Receiving Information

_____
Address of Person/Facility

_____
City, State Zip Code Telephone:

For the following dates of treatment *(if known)*: From _____ To_____

Type of information to be disclosed:

- ☐ Psychosocial Assessment
- ☐ Discharge Summary/Aftercare Plan
- ☐ Treatment Plan
- ☐ Substance Abuse Assessment
- ☐ Physician/Medical Provider progress notes
- ☐ Therapy (non-psychotherapy notes)
- ☐ Case Management Notes
- ☐ Medication Administration Records/Injection logs
- ☐ Lab Results
- ☐ Medication List
- ☐ Diagnoses List
- ☐ Letter of admit/discharge Dates
- ☐ Other (List other specific documents or information) _____

Those records approved for disclosure above which contain tobacco/drug/alcohol/other substance use information (CLIENT 14 YEARS OF AGE AND OLDER/LEGAL GUARDIAN MUST INITIAL ONE):

May be released _____ May not be released_____

Approved method of disclosure/release: ☐ Mail ☐ Verbal ☐ Given to Client
☐ Fax to this number: _____ ☐ Secure email address: _____

Purpose of Disclosure: Coordination of care ☐ Social Security ☐ Legal ☐ Other (explain): _____

I also understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it, and that in any event this authorization expires automatically as follows: _____, or if unspecified, one (1) year after the client's dated signature (below). Revocations should be submitted to the health information department where the information and appropriate revocation forms are kept.

I understand that my records are currently protected by Oklahoma State Statutes and federal privacy regulations including the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 & 164. I understand that my health information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may redisclose the information and it may no longer be protected by the HIPAA privacy law. When applicable, the federal regulations governing the confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, prohibits redisclosure of such information without my specific written consent or when permitted by such regulations.

I understand that the covered entity and/or program seeking this authorization will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I freely and voluntarily give this consent.

I understand that I am entitled to receive a copy of this authorization after it is signed.

I acknowledge information authorized for release may include records which may indicate the presence of a communicable or noncommunicable disease, including but not limited to diseases such as venereal disease, hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

Signature of Client (age 14 and older)	Date	Printed Name	Staff Name (1st initial, last name)
	/		
Signature of Parent/Legal Guardian	Date	Printed Name	Relationship
	/		

A photocopy of this authorization shall be considered as valid as the original. SP/Forms/Standardized Releases/Standard 7.22.19, rev. 8.20.19, rev. 9.10.19, Revised 01.30.2024