

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:

- | | | |
|---|---|--|
| <input type="checkbox"/> Psychosocial Assessment | <input type="checkbox"/> Physician/Medical Provider progress notes | <input type="checkbox"/> Lab Results |
| <input type="checkbox"/> Discharge Summary/Aftercare Plan | <input type="checkbox"/> Therapy (non-psychotherapy notes) | <input type="checkbox"/> Medication List |
| <input type="checkbox"/> Treatment Plan | <input type="checkbox"/> Case Management Notes | <input type="checkbox"/> Diagnoses List |
| <input type="checkbox"/> Substance Abuse Assessment | <input type="checkbox"/> Medication Administration Records/Injection logs | <input type="checkbox"/> Letter of admit/discharge Dates |
| <input type="checkbox"/> 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 (1 st initial, last name)
Signature of Parent/Legal Guardian	/	Date	Printed Name	Relationship