COUNSELING AND RECOVERY SERVICES OF OKLAHOMA

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION (CALM CENTER)

CONSUMER NAME (Please print) MR CHART # M ☐ F ☐	AGE	DATE OF BIRTH
ADDRESS CITY STATE ZIP	TELEPHONE	

I give my consent freely and voluntarily for Counseling and Recovery Services of Oklahoma to receive and/or release copies of my medical record, which may include mental health and/or substance abuse information. Copies of my medical record may (initial one or both, as appropriate):

_____**Be released to:**

and/or

_____**Be obtained from:**

Name:_____

Address:_____

City/State/Zip:_____

Telephone #:_____

Relationship to Consumer: _____

The purpose of this release (check one):

_____ Continuity of Care

_____Social Security Disability

_____Other (explain): _____

_____

FOR INFORMATION RELEASED BY COUNSELING AND RECOVERY SERVICES OF OKLAHOMA ONLY (initial the approved method):

_____ **mail** _____ **verbal**

_____ **fax** (with approval of Medical Records Department)

INFORMATION TO BE RELEASED (CHECK ONE OR MORE OF THE BOXES:

____Discharge Summary/Plan	____Diagnosis
____Psychosocial Assessment	____Medication Records
____Psychiatric Evaluation	____Lab/Radiology
____Nursing Assessment	____HIV/AID's status:_____
____Multidisciplinary Progress Notes	____Other:_____
____Physician's Orders	_____

INFORMATION TO BE RELEASED COVERS SERVICES BETWEEN

_____ and _____ (Insert either date(s) or "all.")

AUTHORIZATION TO RELEASE INFORMATION TO: _____

ACKNOWLEDGEMENTS:

I HEREBY AUTHORIZE **COUNSELING AND RECOVERY SERVICES OF OKLAHOMA** AND ITS EMPLOYEES TO RELEASE OR OBTAIN INFORMATION AND COPIES OF RECORDS PERTAINING TO MY MEDICAL CARE AND TREATMENT. **THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE. (63 O.S. 1992, 1-502.2.B, eff. 11/1/2007)**

I understand that my records are currently protected under the Federal privacy regulations within the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR, Parts 160 & 164**. I further understand that the information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may re-disclose the information and it may no longer be protected by the HIPAA privacy law.**

DRUG/ALCOHOL ABUSE RECORDS: I understand that my records may be protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. State and Federal law regulations prohibit any further disclosure of such records without my specific written consent or when otherwise permitted by regulation.

TITLE 43 A, MENTAL HEALTH LAW OF OKLAHOMA: Consumers may access/obtain copies of their mental health, drug, or alcohol abuse treatment records unless access is likely to endanger the life or physical safety of the consumer or another person as determined by the clinician in charge of the care and treatment of the consumer.

CONSUMERS REFERRED BY THE CRIMINAL JUSTICE SYSTEM: The information disclosed may only be re-disclosed to carry out the recipient's official duties with regard to the consumer's criminal proceeding in reference to which the consent to release confidential information was made by the consumer.

I understand that treatment, payment, enrollment in the health plan, or eligibility for benefits services are not contingent upon or influenced by my decision to permit the information release.

I understand the specific type(s) of information that has been requested for release and the period of time for which the information has been requested.

I understand if the person/organization authorized to receive my protected health information is not a health plan or health care provider, privacy regulations may no longer protect the information.

I understand I may inspect or obtain a copy of the protected health information shared under this authorization by sending a written request to the COUNSELING AND RECOVERY SERVICES OF OKLAHOMA Privacy Officer, 7010 S. Yale Ave., Suite 215, Tulsa, OK, 74136.

I understand that I may revoke this consent at any time in writing unless action has already been taken based upon it. Should I decide to revoke this authorization prior to its expiration, I must submit my revocation in writing to the COUNSELING AND RECOVERY SERVICES OF OKLAHOMA Privacy Officer, 7010 S. Yale Ave., Suite 215, Tulsa, OK, 74136.
I give my consent freely and voluntarily for information to be released.

THIS CONSENT EXPIRES AUTOMATICALLY IN NINETY (90) DAYS FROM DATE SIGNED UNLESS OTHERWISE NOTED.

This Consent Shall Expire: _____

Signature of Consumer: _____ Date: _____

Printed Consumer or Legal
Guardian Name: _____

Signature of Legal Guardian: _____ Date: _____

Capacity of Legal Guardian (if applicable): _____

Consumer/Guardian Offered Copy of this Authorization ☐ Consumer Accepted Copy ☐ Consumer Declined Copy
To obtain records authorization was mailed____ or faxed___ date_____ by_____