OKLAHOMA DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
Consent for Release of Confidential or Protected Information

(Name of consumer)	(Record #)	(Date of birth)	(Social Security Number)

I authorize: Bill Willis CMHCSAS/Cherokee Co. SOC Staff **to release to:** _____
Name of Person or Facility Releasing Information and Name of person / facility receiving information

☐**exchange with:**

PO Box 558, Tahlequah, OK. 74464 (check if applicable) _____
Address of Person or Facility Releasing Information Address of person or Facility Receiving Info

_____ _____

the following information for the following dates of treatment: _____ (if known).

In boxes below, I am indicating information to be disclosed from any medical/mental health/substance abuse records:

__ Psychiatric Evaluation/Assessment	__ DischargeAftercare Plan	__ Lab / X-ray reports
__Assessment(s): _____	__ Release/Discharge Summary	__ Medications
__ _____	__ History & Physical Exam	__ Diagnoses
__ Treatment plan/update	__ Letter of admit/discharge dates	__ Billing/financial info
Other – List specific documents(s) or information: Any and all written, verbal and faxed information necessary to facilitate the wraparound process.		

Information is being released for the following purpose: Facilitation and coordination of wraparound

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: **discharge/termination**, or if unspecified, one (1) year after the patient'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.

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE. *63 O.S. 1-502.2.B, eff. 11/1/2007)*

_____ /_____ _____/_____
Signature of consumer Date Witness (Optional) Date

_____ /_____ _____
Signature of authorized representative or parent or guardian when required Date Relationship to consumer

A photocopy of this authorization shall be considered as valid as the original.

DMHSAS 3.5(A) Revised 09/03/02; 04/14/03; 04/07/04; 1/16/08