

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I understand that records are protected under Federal and State Confidentiality Law and Regulations and cannot be disclosed without my/our written consent unless otherwise provided for in the laws and regulations. I/We do hereby authorize:

Name, Title, Organization, and Address: Logan County Systems of Care, P.O. Box 1621-Guthrie, OK 73044

To release to:

Name, Title, and Organization: Logan County Systems of Care Referral Team

The following information/records regarding: (Name of Consumer) _____, **DOB:** ____/____/____
for records covering the time period ____/____/____ through ____/____/____.

Description of information being disclosed:

Specific reason for the disclosure:

To provide wraparound services.

“The information authorized for release may include records which may indicate the presence of a communicable or noncommunicable disease.” [63 O.S. § 1-1502 (B)].

Re: Psychiatric Records – Oklahoma State Law (76 O.D. Supp. 1986, Section 19) provides that psychological or psychiatric records may be provided to a patient if the treating physician or practitioner consents to the release upon receipt of a court order, issued by a court of competent jurisdiction. Therefore psychological or psychiatric records will not be released to patients, their guardians or agents (including attorneys) except with the consent of the treating physician or practitioner or upon the receipt of a court order, issued by a court of competent jurisdiction.

Re: Drug/Alcohol Abuse Records – Confidentiality of drug/alcohol abuse records is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol/drug abuse patient.

This release is in effect from: ____/____/____ through ____/____/____ **or for the specific event** _____,

and the release will last no longer than reasonably necessary to serve the purpose for which it is given.

I/We (consumer or legally authorized representative) understand that I/We may revoke this consent in writing at any time except to the extent that actions have been taken in reliance on it. This consent is being given freely and voluntarily. I/We understand that treatment services are not contingent upon or influenced by my/our decision to permit the release of information.

_____	_____	_____	_____
Consumer	Date	Parent/Guardian or Legally Authorized Representative	Date
_____	_____	_____	_____
Staff/Witness/Credentials	Date	Clinician’s Review (if release is to consumer/family member)	Date

