

**OKLAHOMA DEPARTMENT OF MENTAL HEALTH
AND SUBSTANCE ABUSE SERVICES
CARL ALBERT COMMUNITY MENTAL HEALTH CENTER**

Consent for Release of Confidential Information

I, _____ (NAME OF CONSUMER) _____ (Record #) _____ (Date of Birth) _____ (Social Security Number)

Authorize: _____ **to release to:** _____
Name of Person or Facility Releasing Information Name of Person or Facility Receiving Information

Address of Person or Facility Releasing Information Address of Person or Facility Receiving Information

the following information:

Discharge/Aftercare Plan _____	Lab Reports _____	Letter of admit & discharge dates _____
Treatment Plan _____	X-Ray Reports _____	Medications _____
Physical Exam _____	Doctor's Notes _____	Release/Discharge Summary _____
Other -List specific document(s) or information: _____		

Dates of Treatment, if known: _____

Method by which information is to be released: Mail: _____ Fax: _____ Verbal: _____ Hand Carried- Given to Client: _____

Information is being released for the following purpose: _____

Date, Event, or Condition when Consent Expires: _____
In the event no date, event, or condition is specified for expiration, this consent expires in ninety (90) days from the date of signing.

I understand that treatment services are NOT contingent upon or influenced by my decision to permit the information release. I also understand that I or my legally authorized representative may revoke this consent in writing at any time unless action has already been taken based upon it. This consent may be revoked by submitting a written revocation to the health information department. I freely and voluntarily give this consent.

I understand that the records requested may be protected under 42 C.F.R. Part 2, governing Alcohol and Drug Abuse patient records, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, State Confidentiality laws and regulations and cannot be released without my consent unless otherwise provided for by regulations. State and Federal law regulations prohibit any further disclosure of such records without my specific written consent or when otherwise permitted by such regulation.

THE INFORMATION I AUTHORIZE FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

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

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

DMHSAS 3.5(A) Revised 09/03/02; 04/14/03; 04/07/04 CACMHC POLICY 3-9-20