

**RED ROCK BEHAVIORAL HEALTH SERVICES
AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL INFORMATION**

I, _____ (Name of Client) _____ (Date of Birth) _____ (Social Security #) _____ (Chart #)

HEREBY AUTHORIZE: _____ TO COMMUNICATE & EXCHANGE INFORMATION WITH:
RED ROCK BEHAVIORAL HEALTH SERVICES _____

the information indicated below for the following purpose(s) (Client must initial or check):
____ Treatment planning _____ Responsible Party/Family Member/Emergency Contact
____ Submission of court/progress reports _____ Follow-up
____ Insurance Eligibility/health benefits _____ Other (specify) _____

PERIOD OF TIME COVERED BY INFORMATION TO BE RELEASED: _____

METHOD OF RELEASE (please check all that apply): Fax Written Verbal Video Audio

REPORTS TO BE FURNISHED (Client must initial or check):
____ Psychosocial Assessment _____ Medication Record _____ Psychological Testing
____ Health & Medication History _____ Progress Notes _____ Discharge Summary
____ Alcohol & Other Drug Information _____ Treatment Plans _____ Other _____
____ Intake Assessment (Part II) _____

Notice to recipients of alcohol and drug abuse records:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the 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 or drug abuse patient.

The information you authorize for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, tuberculosis, and the human immunodeficiency virus (HIV), also know as Acquired Immune Deficiency Syndrome (AIDS). Further, the information authorized for release may indicate the presence of a communicable or non-communicable disease (63 O.S. § 1-502-2).

Clients referred by the Criminal Justice System – The information disclosed may only be redisclosed to carry out the recipient’s official duties with regard to the client’s criminal proceeding in reference to which the consent to release confidential information was made by the client.

I understand that my records are protected under the Federal and State Confidentiality regulations and cannot be released without my written consent unless otherwise provided for in the regulations. Federal regulations prohibit Red Rock Behavioral Health Services from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. I also understand that I (or my legally authorized representative) may revoke this consent (in writing) at any time by contacting a Red Rock staff member unless action has already been taken. A photocopy of this authorization shall be considered as valid as the original. This consent will expire when all third (3) party payer claims are satisfied or not to be exceeded one year from the date signed. (For clients who have been referred by the Criminal Justice System, this consent expires no later than the date of final disposition of any criminal proceedings).

I further understand that my treatment services are not contingent upon, or influenced by, my decision to permit the information release, and by signing below, I indicate that my consent to the release of this information is given freely and voluntarily.

Client's Signature

Date

Signature of Witness

Date

Signature of parent, guardian, or authorized representative
(Relationship to Client _____)

Date