



Counseling Center of SE Oklahoma
P.O. Box 1030, 107 S. High Street
Antlers, Oklahoma 74523

Consent for Release of Confidential Information

I, _____ / _____ / _____ authorize the Counseling Center of SE
FIRST MI LAST DATE OF BIRTH

Oklahoma and the following agencies, entities, or people to release and disclose to one another the following types of information: behavioral information, medical reports, test results, psychological reports and results, treatment plans, summary reports, other _____. Information released or disclosed will be used to coordinate, evaluate, plan and/or continue appropriate treatment or program, determine eligibility for benefits or program, case review, and/or update files. Released information may be subject to re-disclosure by the recipient, resulting in the information no longer being protected. This consent is valid from: (start date) _____ to (end date) _____.

Release and/or Obtain	Initial for Consent	Name <u>and address</u> of agency, entity, or person to release to or obtain information from:
<input type="checkbox"/>		School Contact:
<input type="checkbox"/>		Doctor:
<input type="checkbox"/>		Community Referral:
<input type="checkbox"/>		Referral Source:
<input type="checkbox"/>		DHS / Child Welfare / DOC / APS If TANF - Must also use ODMHSAS release form
<input type="checkbox"/>		Community Sentencing Program
<input type="checkbox"/>		Drug Court Team
<input type="checkbox"/>		Multi-Disciplinary Team
<input type="checkbox"/>		Family member:
<input type="checkbox"/>		Family member:
<input type="checkbox"/>		Redwood Toxicology Lab
<input type="checkbox"/>		Other:

I understand my medical records and all clinical information are confidential and are protected under the provisions of 43A OS & 1-109. I understand medical records and all communications between consumer and doctor or psychotherapist are privileged and confidential; with such information limited to persons or agencies actively engaged in my treatment or related to administrative tasks. I understand privileged and confidential information shall not be released without my written, informed consent. I understand that treatment is not contingent upon or influenced by my decision to permit this information release. My consent is given freely and voluntarily. **The information authorized 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). (63 O.S. sec. 1-1502(B)).** If any criminal proceeding is involved, disclosure is bound by federal laws and regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 U.S.C. #290DD-2; 42 C.F.R., Part 2) and recipients of the information may receive and disclose it only in connection with their official duties with respect to the particular criminal proceeding and may not use the information in other proceedings, for other purposes, or with respect to other individuals.

I understand that I may revoke this consent in writing at any time by signing and dating the revocation line at the bottom of this page, except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically one year following the date I stopped receiving services from CCSO. Revocation must be submitted to the Antlers office. However, if any criminal proceeding is involved, this consent is irrevocable until final disposition of the proceeding, and expires upon final disposition of the proceeding.

Consumer Signature

Date

Parent/Guardian/Legally Authorized Representative

Date

Consent Informer Signature and Title

Date

I hereby revoke this consent _____
Signature

Date