



ASSOCIATED CENTERS FOR THERAPY, INC.

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION (STANDARD)

CONSUMER NAME (Please print)	M <input type="checkbox"/>	AGE	DATE OF BIRTH
	F <input type="checkbox"/>		

I HEREBY AUTHORIZE **ASSOCIATED CENTERS FOR THERAPY, INC.** AND ITS EMPLOYEES TO RELEASE OR OBTAIN INFORMATION AND COPIES OF RECORDS PERTAINING TO MY MEDICAL CARE AND TREATMENT. **THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE.** (63 O.S. 1992, 1-502.2.B, eff. 11/1/2007)

ASSOCIATED CENTERS FOR THERAPY, INC. (CHECK ONE OR BOTH)	NAME Wraparound Tulsa		
MAY RELEASE TO <input type="checkbox"/>	ADDRESS 7010 S. Yale, Suite 100		
MAY OBTAIN FROM <input type="checkbox"/>	CITY, STATE, ZIP CODE Tulsa, OK 74136-5713		
	TELEPHONE # (918) 492-2554, ext. 330	FAX # (918) 495-0779	
CHECK APPROPRIATE BOX(ES):		THE PURPOSE OF THIS REQUEST:	
<input type="checkbox"/> Copies of information pertaining to my mental health and/or substance abuse and/or medical treatment for the following time period _____ <input type="checkbox"/> Exchange of verbal information		<input type="checkbox"/> Continuity of Care <input type="checkbox"/> Disability Determination <input type="checkbox"/> Discharge Planning <input type="checkbox"/> Other (explain):	
INFORMATION REQUIRED	<input type="checkbox"/> Diagnosis	<input type="checkbox"/> Psychological Testing	<input type="checkbox"/> Medication Pick-up
<input type="checkbox"/> Intake/Assessment Note	<input type="checkbox"/> Treatment Plan	<input type="checkbox"/> Psychiatric Evaluation	<input type="checkbox"/> Discharge Summary
<input type="checkbox"/> Clinician Progress Notes	<input type="checkbox"/> Lab Results	<input type="checkbox"/> Psychosocial Assessment	<input type="checkbox"/> Attendance Information
<input type="checkbox"/> Physician Progress Notes	<input type="checkbox"/> Physician Orders	<input type="checkbox"/> Prescriptions	<input type="checkbox"/> Scheduling
<input type="checkbox"/> Nursing Notes	<input type="checkbox"/> History and Physical	<input type="checkbox"/> Other:	

DRUG/ALCOHOL ABUSE RECORDS: I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. State and Federal law regulations prohibit any further disclosure of such records without my specific written consent or when otherwise permitted by regulation.

TITLE 43 A, MENTAL HEALTH LAW OF OKLAHOMA: Consumers may access their mental health, drug, or alcohol abuse treatment records unless access is likely to endanger the life or physical safety of the consumer or another person as determined by the clinician in charge of the care and treatment of the consumer.

CONSUMERS REFERRED BY THE CRIMINAL JUSTICE SYSTEM: The information disclosed may only be re-disclosed to carry out the recipient's official duties with regard to the consumer's criminal proceeding in reference to which the consent to release confidential information was made by the consumer.

I understand that my records are currently protected under the Federal privacy regulations within the **Health Insurance Portability and Accountability Act (HIPAA), 45 CFR, Parts 160 & 164.** I further understand that the information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may re-disclose the information and it may no longer be protected by the HIPAA privacy law.

I understand that treatment, payment, enrollment in the health plan, or eligibility for benefits services are not contingent upon or influenced by my decision to permit the information release.

Also, I understand that I may revoke this consent at any time in writing unless action has already been taken based upon it. Should I decide to revoke this authorization prior to its expiration, I must submit my revocation in writing to the ACT Privacy Officer, 7010 S. Yale Ave., Suite 215, Tulsa, OK, 74136. **THIS CONSENT EXPIRES AUTOMATICALLY IN NINETY (90) DAYS UNLESS OTHERWISE NOTED.**

This Consent Shall Expire: _____

Signature of Consumer: _____ **Date:** _____
Signature of Parent/Guardian/Representative: _____, **Relationship:** _____ **Date:** _____

Consumer Accepted Copy of this Authorization Yes No