



CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, \_\_\_\_\_ Name of client Soc Sec No. \_\_\_\_\_ Date of Birth \_\_\_\_\_

AUTHORIZE:

\_\_\_\_\_  
Name of Releasing Agency or Person Name of Agency or Person Receiving Information

\_\_\_\_\_  
Address Phone Address Phone

Reason for releasing information \_\_\_\_\_

\*\*\*\*\*PLEASE CHECK INFORMATION REQUIRED\*\*\*\*\*

- ( ) Psychological Testing ( ) Consultations ( ) Physicians Orders ( ) SCHOOL GRADES
( ) Discharge Summary ( ) Progress Notes ( ) Treatment Plan ( ) DISCIPLINARY REPORTS
( ) Health & Drug History ( ) Lab Work, EKG ( ) Psychosocial ( ) I.E. P. RECORDS
( ) S.E.D. RECORDS

( ) Other \_\_\_\_\_

CHECKING THE ABOVE (HEALTH & DRUG HISTORY), (LAB WORK), OR (PHYSICIANS ORDERS) MAY RESULT IN THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION 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).

DRUG/ALCOHOL ABUSE RECORDS: THE CONFIDENTIALITY OF DRUG/ALCOHOL ABUSE RECORDS IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATIONS (42 C.F.R. PART 2 ) PROHIBITS YOU FROM MAKING ANY FURTHER DISCLOSURE OF RECORDS WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED BY SUCH REGULATIONS. A GENERAL AUTHORIZATION FOR RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE.

PSYCHIATRIC RECORDS: OKLAHOMA STATE LAW, (76 O.S. SUPP. 186 SECTION 19). PROVIDES THAT PSYCHIATRIC RECORDS MAY NOT BE PROVIDED TO A PARENT, THEIR GUARDIANS OR AGENTS WITHOUT CONSENT OF THE PRACTITIONER OR AN ORDER FROM THE COURT OF COMPETENT JURISDICTION.

I UNDERSTAND THAT MY RECORDS ARE PROTECTED UNDER FEDERAL AND STATE CONFIDENTIALITY REGULATIONS AND CANNOT BE RELEASED WITHOUT MY WRITTEN CONSENT UNLESS OTHERWISE PROVIDED FOR IN THOSE LAWS AND REGULATIONS. I FURTHER ACKNOWLEDGE THAT THE INFORMATION TO BE RELEASED WAS FULLY EXPLAINED TO ME AND THIS CONSENT WAS GIVEN OF MY OWN FREE WILL. I UNDERSTAND THAT I HAVE THE RIGHT TO LEGAL COUNSEL OF MY CHOICE AND EXPENSE, AND AM ENTITLED TO ALL DUE PROCESS PROTECTION AFFORDED BY LAW. I ALSO UNDERSTAND THAT I OR MY LEGAL REPRESENTATIVE MAY REVOKE THIS CONSENT AT ANY TIME IN WRITING UNLESS ACTION HAS ALREADY BEEN TAKEN BASED UPON IN THAT IN ANY EVENT. A RELEASE MAYBE REVOKED BY CONTACTING ANY CREEKS CLINICIAN. THIS CONSENT EXPIRES AUTOMATICALLY IN 1 YEAR FROM DATE SIGNED OR WHEN EVENT IS COMPLETED.

This Consent Expires \_\_\_\_\_ OR \_\_\_\_\_ (DATE) (COMPLETION OF EVENT)

SIGNATURE OF CLIENT \_\_\_\_\_ DATE \_\_\_\_\_

SIGNATURE OF \_\_\_\_\_ DATE \_\_\_\_\_ RESPONSIBLE PARTY (PARENT, GUARDIAN, OR REPRESENTATIVE)

RELATIONSHIP TO CLIENT \_\_\_\_\_

WITNESS SIGNATURE \_\_\_\_\_

\* The information authorized for release was faxed/mailed by:

\_\_\_\_\_  
Name of Staff Sending Information Date Sent