Counseling & Recovery Service of OK (CRS)

Consent for Release of Confidential or Protected Health Information

Name of Client, printed	Client ID #	Date of Birth	Last 4 #s of SS#

Address City/State and Zip Code	City/State and Zip Code	Telephone #

I authorize information to be released from CRS to ☐ and/or obtained from ☐:

Name of Person or Facility	Telephone #

Address	City/State and Zip Code

Dates of information to be released: _____

In the boxes I have initialed below, I am indicating this information may be disclosed from any medical, mental health, or substance abuse record:

____ Psychosocial Assessments	____ Physician/Medical Provider progress notes	____ Lab Results
____ Discharge Summary/Aftercare Plan	____ Therapy (non-psychotherapy notes)	____ Medication List
____ Treatment Plans	____ Case Management Notes	____ Diagnoses List
____ Substance Abuse Assessments	____ Medication Administration Records/Injection	____ Letter of admit/discharge
____ Nursing History and Assessments	logs	Dates

Other: List other specific documents or information:

Those records approved for disclosure above which contain tobacco/drug/alcohol/other substance use disorder information (CLIENT, 14 YEARS AND OLDER MUST initial one): May be released _____ May not be released _____

Approved method of disclosure/release (initials): _____ Mail; _____ Verbal; _____ Given to Client

_____ Fax to this fax number: _____

_____ Encrypted/Secure email address: _____ Other: _____

Purpose of Disclosure: Continuity of care _____; Social Security _____; Other (explain): _____

I also understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it, and that in any event this authorization expires automatically as follows: _____, or if unspecified, one (1) year after the client's dated signature (below). Revocations should be submitted to the health information department where the information and appropriate revocation forms are kept.

I understand that my records are currently protected by Oklahoma State Statutes and federal privacy regulations including the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 & 164. I understand that my health information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may redisclose the information and it may no longer be protected by the HIPAA privacy law. When applicable, the federal regulations governing the confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, prohibits redisclosure of such information without my specific written consent or when permitted by such regulations.

I understand that the covered entity and/or program seeking this authorization will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I freely and voluntarily give this consent.

I understand that I am entitled to receive a copy of this authorization after it is signed.

I acknowledge information authorized for release may include records which may indicate the presence of a communicable or noncommunicable disease, including but not limited to diseases such as venereal disease, hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

Signature of Client (age 14 and older)	Date	Printed Name	Staff Name (1st initial, last name)

Signature of Parent/Legal Guardian	Date	Printed Name	Relationship

A photocopy of this authorization shall be considered as valid as the original.