Counseling + Recovery SERVICES

Client ID_____

Consent for Release of Confidential or Protected Health Information

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

Authorize: Counseling and Recovery Services
1323 E. 71st St.
Tulsa, OK 74136
Ph: 918-492-2554
Fax: 918-499-1598

Release To ☐
Obtain From ☐

_____
Name of Person & Facility Receiving Information

_____
Address of Person/Facility

_____
City, State Zip Code Telephone:

For the following dates of treatment: From _____ to _____

Type of information to be disclosed:

- ☐ Psychosocial Assessment
- ☐ Discharge Summary/Aftercare Plan
- ☐ Treatment Plan (PCP)
- ☐ Substance Abuse Assessment
- ☐ Educationally Relevant Information (School)
- ☐ Physician/Medical Provider Progress Notes
- ☐ Nursing History/Assessment (PCP)
- ☐ Therapy (non-psychotherapy notes)
- ☐ Case Management Notes
- ☐ Medication Administration/Injection Records
- ☐ Lab Results (PCP)
- ☐ Medication List (PCP)
- ☐ Diagnoses List (PCP)
- ☐ Period of treatment
- ☐ Other (List other specific documents or information) _____

Those records approved for disclosure above which contain tobacco/drug/alcohol/other substance use information (CLIENT 14 YEARS OF AGE AND OLDER/LEGAL GUARDIAN MUST INITIAL ONE):

Note: For substance use treatment records, only the minor may authorize disclosure if they consent to treatment under Oklahoma law.

May be released _____ May not be released_____

Approved method of disclosure/release: ☐ Mail ☐ Verbal ☐ Given to Client ☐ Electronic Health Record (EHR) Portal
☐ Fax to this number: _____ ☐ Secure email address: _____

Purpose of Disclosure: ☐ Coordination of care ☐ Disability Benefits ☐ Housing Records ☐ Personal Records

Legal Reasons: ☐ Custody ☐ Court Proceedings ☐ DHS Processing ☐ Employment Purposes ☐ Education Purposes

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; ☐ **after 90 days** ☐ **after one year** ☐ **at time of discharge** ☐ **upon change of school**

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.

CAO 08.12.2025 (Edited by J. Busque, HIM Director)