OKLAHOMA DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
Multi-Party Consent for Release of Confidential or Protected Information

Name of consumer: **Record #:** **Date of birth:** **Social Security Number:**

I authorize the _____(name of program)

to communicate or share with any of residential treatment providers named in the list of providers **on the back of this form**:

Method(s) by which information is to be released*:* ☐Mail ☐Fax ☐Verbal ☐Hand carried or given to consumer

In the boxes below, I am indicating information to be disclosed from any medical/mental health/substance abuse records:		
☐ Psychiatric Evaluation/Assessment	☐ DischargeAftercare Plan	☐ Lab / X-ray reports
☐Assessment(s):	☐ Release/Discharge Summary	☐ Medications
	☐ History & Physical Exam	☐ Diagnoses
☐ Treatment plan/update	☐ Letter of admit/discharge dates	☐ Billing/financial info
☐ Other – List specific documents(s) or information:		

Information is being released for the following purpose:.

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 patient'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.

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE. (63 O.S. 1-502.2.B, eff. 11/1/2007)

_____ /_____ _____/_____
Signature of consumer Date Witness (Optional) Date

_____ /_____ _____
Signature of authorized representative or parent or guardian when required Date Relationship to consumer

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

Contracted Substance Use Disorder Residential Treatment Providers

☐ 12 & 12, Inc.	
☐ Alpha II	
☐ Catalyst Behavioral Services (Drug Recovery, Inc.)	
☐ Eagle Ridge Institute	
☐ House of Hope, Inc.	
☐ Kibois Community Action Foundation Inc. (The Oaks Rehabilitative Services Cntr)	
☐ MONARCH, Inc.	
☐ New Hope of Mangum	
☐ Northeastern Oklahoma Council on Alcoholism	
☐ Northwest Substance Abuse Treatment Center for Women and Children	
☐ Roadback, Inc.	
☐ Valliant House, LLC.	
