**Name of your agency here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Multi-Party Consent for Release of Confidential or Protected Information**

**Name of consumer:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Record #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I authorize the \_\_\_\_\_\_\_\_[outpatient program]\_\_\_\_\_\_\_\_\_\_\_

to communicate or share with any of residential treatment providers named in the list of providers **on the following page.**

**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:** | | |
| Substance Use Disorder Evaluation | Medications | Discharge Summary |
| Screening/Assessment(s): | Billing/Financial Info | Discharge Plan |
| Diagnoses | History & Physical Exam | Legal |
| Lab Reports | Treatment Plan Update |  |
| Other – List specific documents(s) or information: | | |

**Information is being released for the following purpose:** Transfer from the interim service provider to the residential treatment service provider.

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: Upon successful placement in residential, 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. Effective date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 re-disclose 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 re-disclosure 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 Date Relationship to consumer

parent or guardian when required

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

**Contracted/Residential & Mental Health – Substance Abuse Treatment Providers**

|  |
| --- |
| 12 & 12, Inc. |
| Alpha II |
| Bridges to Recovery / Jim Taliaferro |
| Catalyst Behavioral Services (Drug Recovery, Inc.)/Community House |
| Eagle Ridge Institute / Family Treatment Center |
| House of Hope, Inc. |
| Kibois Community Action Foundation Inc./The Oaks Rehabilitative Services Cntr |
| Monarch Residential (Women) |
| Northeastern Oklahoma Council on Alcoholism (NOCA) |
| Northwest Center for Behavioral Health / The Lighthouse |
| Northwest Substance Abuse Treatment Center |
| Red Rock Behavioral Health Services / Jordan’s Crossing |
| Roadback, Inc. / Pathways |
| Rose Rock Recovery Center (VADTC) |
| Tulsa Women & Children’s Center (TWCC) /Palmer Continuum of Care |
| Valliant House, LLC. |
| Waynoka Mental Health Authority **dba** Northwest Treatment Center |
|  |
|  |
|  |
|  |
|  |