

# Strength of Mind

2990 N. Sioux  
Claremore, OK 74017  
(918) 342-2622 (ph)  
(918) 342-2641 (fax)

8937 S. Garnett  
Broken Arrow, OK 74012  
(918) 872-9777 (ph)  
(918) 872-9779 (fax)

## CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I hereby authorize and request Strength of Mind or one of its delegates to \_\_\_\_\_ Release to \_\_\_\_\_ Obtain from \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

pertinent confidential information regarding: \_\_\_\_\_

DOB: \_\_\_\_\_

State and federal regulations restrict the distribution of mental health and substance abuse records. Federal rules prohibit the recipient from making any further disclosure of this information unless expressly permitted by written consent or as otherwise provided by law. A general authorization for release of medical or other information is not sufficient for this purpose. (42 CFR Part 2). All records and communication between patient and clinicians are both privileged and confidential. Such records may only be released upon written authorization by the patient or legal guardian or as otherwise provided by law. A patient or legal guardian may authorize release of records to an attorney or other third part, but that authorization does not permit the patient's personal access to records (12 OS, Sec. 2503; 43 OS, Sec. 1-109; 59 OS, Sec. 1376; 76 OS, Sec. 19)

**THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR INCOMMUNICABLE DISEASE. (63 OS, SEC. 1-502, 2)**

Information to be Released: \_\_\_\_\_

\_\_\_\_\_

Purpose of Disclosure: \_\_\_\_\_

This authorization will expire the later of \_\_\_\_\_ or 90 days after signing.

I release the parties named above from liability arising from my disclosure pursuant to this authorization. I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to the parties named above. I understand, however, that my revocation will not be effective to the extent that action has been taken in reliance on this authorization, or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has the right to contest a claim.

I understand that my healthcare provider generally may not condition psychological services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the HIPAA Privacy Rule. I certify that I have the required legal standing for myself or, in the case of a minor child, have legal custody and/or other required legal right to authorize the release of confidential information. A copy of this information is to be considered as valid as the original.

Print Name

Signature

Date

If this authorization is signed by a parent or other personal representative of a patient, a description of such representative's authority to act for the patient must be provided.