RED ROCK BEHAVIORAL HEALTH SERVICES
AUTHORIZATION TO RELEASE/OBTAIN PROTECTED HEALTH INFORMATION (PHI)

I, _____ _____ _____ _____
(Full legal name of client) (Date of Birth) (Social Security #) (Chart #)

HEREBY AUTHORIZE:

RED ROCK BEHAVIORAL HEALTH SERVICES

TO COMMUNICATE & EXCHANGE WITH:

Name of agency and/or person

Address

City/State/Zip

Phone Number Fax Number

Purpose of Request (Client must initial or check):

☐ Care Coordination ☐ Release Medical Records ☐ Obtain Medical Records

THE FOLLOWING INFORMATION * (Client must initial or check):

☐ BioPsychosocial Assessment	☐ Progress Notes	☐ Screening Information	☐ Physical Examination
☐ Medication List	☐ Treatment Plans	☐ Nursing Ass't.	☐ Other (must specify):_____
☐ Diagnosis	☐ Internal Psychiatric Eval.	☐ Case Management Ass't.	_____
☐ Discharge Summary	☐ Lab Reports	☐ ASI	_____
☐ Appointment scheduling/Office Visit	☐ Intervention Tx. Notes		

PERIOD OF TIME COVERED BY INFORMATION TO BE RELEASED: _____ to _____

* The undersigned agrees that any of the items checked above may include any and all substance use disorder information contained in such record, except as specifically limited as follows:_____

FOR THE FOLLOWING PURPOSE(S). (Client must initial or check):

☐ Treatment Planning/Coordination of Care/Client Advocacy ☐ Responsible Party/Family member ☐ Legal Representation

☐ Submission of court/progress reports ☐ Continued Treatment ☐ Insurance Eligibility/health benefits ☐ Obtain Housing ☐ Obtain DHS benefits

☐ Obtain Disability benefits ☐ Other (specify): _____

METHOD OF RELEASE (Please check all that apply): ☐ Fax ☐ Written ☐ Verbal ☐ Audio ☐ Encrypted Email

☐ Unencrypted email **(Drug Court or TANF programs ONLY)**
I understand that information sent by unencrypted email may be inadvertently accessed by a person other than the intended recipient. ☐ Yes ☐ No

Notice to recipients of alcohol and drug abuse records:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

The information authorized for release may include records which may indicate the presence of a COMMUNICABLE OR NON-COMMUNICABLE DISEASE. (63 O.S. § 1-502-2).

I understand that the information authorized for release may indicate that I have been treated for psychological, psychiatric or substance use conditions.

Clients referred by the Criminal Justice System – the information disclosed may only be redisclosed to carry out the recipient's official duties with regard to the client's criminal proceeding in reference to which the consent to release confidential information was made by the client.

I understand that my records may be protected under Federal Regulations, (42 C.F.R. Part 2, governing alcohol and drug use patient records, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. parts 160 & 164), and State Confidentiality regulations and cannot be released without my written consent unless otherwise provided for in the regulations. Federal regulations prohibit Red Rock Behavioral Health Services from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. I understand if the person/organization authorized to receive my protected health information is not a health plan or health provider, privacy regulations may no longer protect the information. I also understand that I (or my legally authorized representative) may revoke this consent (in writing) at any time by contacting a Red Rock staff member unless action has already been taken. A photocopy of this authorization shall be considered as valid as the original.

This consent will expire (choose one):

☐ Twelve (12) months from the date signed.

☐ Other (insert date or event) _____(Not to exceed one year from the date of the signature below).

For clients referred by the Criminal Justice System, this consent expires no later than the date of final disposition of any criminal proceedings.

I further understand that my treatment services are not contingent upon, or influenced by, my decision to permit the information release, and by signing below, I indicate that my consent to the release of this information is given freely and voluntarily.

_____ _____
Client's Signature Date

_____ _____
Signature of Witness Date

_____ _____
Signature of Parent, guardian, or authorized representative Date

(Relationship to client _____)