For office use only
Date information sent:
Sent by:

Resilience Counseling, LLC

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Name_____ DOB: _____

I authorize Cara McCarty, LPC to ____ release to ____ obtain from the following person/agency:

NAME		
ADDRESS		
CITY	STATE	ZIP
PHONE NO.	FAX NO.	

This release covers the following information concerning the services I am receiving:

___ Attendance (dates scheduled, attended, and missed/cancelled)
___ Diagnosis
___ Treatment Plan
___ Treatment Progress
___ Other _____

The information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

For the following purposes:

___ To comply with Oklahoma law, OS 310:400-5-3.(k), concerning the provision of concurrent services.
___ To coordinate services.
__ Other

Confidentiality of Records: Resilience Counseling LLC complies with Oklahoma law concerning confidentiality of records including: scheduling of sessions, attendance at sessions, content of sessions, progress of treatment, and all other information contained in client records. None of this information will be released without your written authorization except as required by the following legal exceptions:
(1) as mandated by law; (2) to prevent a clear and immediate danger to a person or persons; (3) where the LMFT, LPC, or LADC is a defendant in a civil, criminal, or disciplinary action rising from the therapy (in which case client confidences may be disclosed only in the course of that action); or (4) if there is a waiver previously obtained in writing, and then such information may be revealed only in accordance with the terms of the waiver.

Re: Drug/ Alcohol Abuse Records - Confidentiality of drug/ alcohol abuse records is protected by Federal Law. The records requested may be protected under 42 C.F.R. Part 2, governing Alcohol and Drug Abuse patient records, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. pts. 160 & 164, State Confidentiality laws and regulations and cannot be released without my consent unless otherwise provided for by regulations. State and Federal law regulations prohibit any further disclosure of such records without my specific written consent or when otherwise permitted by such regulation. **I also understand that recipients of this information may re-disclose it only in connection with their official duties with respect to the particular criminal proceeding and may not be used in other proceedings, for other purposes, or with respect to other individuals.**

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/ drug abuse client.

This release will expire one year from the date of my signature or at any time that I withdraw my consent in writing.

I understand that I have the right to refuse to sign this form, and that I may withdraw my consent at any time, except to the extent that information has already been released.

Signature: _____ Date: _____

Signature of Parent/ Guardian (If Applicable): _____ Date: _____

Signature (Witness): _____ Date: _____