Client Name: _____ Date of Birth: _____

Shortgrass Community Health Center

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

☐ **Receiving** ☐ **Disclosing**

Shortgrass Community Health Center: Mental Health

Name, Title

400 E. Sycamore Hollis, OK 73550

Site Address

580-688-2800

Phone

☐ **Receiving** ☐ **Disclosing**

Name, Title

Site Address

Phone

☐ **Assessment** ☐ **Treatment Plan** ☐ **Other Clinical Documentation** ☐ **Testing** ☐ **Behavioral Report**

☐ **Discharge Information** ☐ **Other Information Pertinent to:** _____

IE: dental care, medical care etc.

The Purpose of This Request is:

This authorization will expire on: _____ **(must be updated after 365 calendar days) OR when the following event occurs: Upon discharge if before the year expiration.**

Treatment is not contingent on signing this release

I hereby authorize the use or disclosure of my protected health information as specified above. This authorization permits disclosure of information about mental illness or substance abuse conditions and other health conditions and information. I understand that this authorization is voluntary and that I may refuse to sign it. **I understand that I may revoke this authorization at any time by giving written notification to my provider or any member of the office staff. My revocation will not affect any action taken in reliance on the authorization before the revocation.** I understand that, if the receiver of information is not a health care provider or a health plan, the information disclosed under this authorization may no longer be protected by state and federal privacy regulations and may be re-disclosed by the recipient. I understand that I should receive a copy of this authorization, even if I do not ask for it.

In compliance with CFR 42, part 2, § 2.22 and O.S 43A, section 1-102, 1-103
Confidentiality of Patient Records

The confidentiality of patient records maintained by this program is protected by State and Federal law and regulations. Generally, the program may not say to a person outside of the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser UNLESS:

1) The patient consents in writing:
2) The disclosure is allowed by a court order; or
3) The disclosure is made to medical personnel in a medical emergency or to a qualified personnel for research, audit, or program evaluation.

Violation of the State and Federal law and regulation by a program is a crime. Suspected violations may be reported to appropriate authorization in accordance with State and Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or Federal laws and regulations do not protect any who works for the program or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

"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). (63 O.S. P 1-1502(B)"

Non-contingency statement: I understand that my failure to sign this form will not result in the withholding of services.

_____ _____

Client Signature (if client is 14 or older) Date

_____ _____

Parent/Guardian Signature (if under 18 or in custody) Date