Integrated Therapy Solutions of Oklahoma, LLC

Release of Confidential Information

I understand that medical records requested are protected under the Federal and State Confidentiality laws and regulations and cannot be released without my consent unless otherwise provided for in the regulations. State and Federal laws and regulations prohibit any further disclosure without the specific written consent of the subject or as otherwise permitted by such regulation. I also understand that the signing of this consent may be revoked **(in writing to program coordinator or designee)** at any time unless action has already been taken based upon it and that in any event this consent expires one year from the date of signature.

I, _____ Request That Information Concerning: _____
(Name of requesting party) (Print Name of Client)

DOB _____ SS _____

Be released and authorize **from**:
(Name/Agency) (Address) (City, State, Zip)
VA/COMMUNITY CARE _____

To exchange with: Integrated Therapy Solutions of Oklahoma, LLC

620 NW 5th St. Suite D
Moore, Oklahoma 73160
Ph: (405) 208-4469 Fax: (405) 208-4472

The following written, verbal and/or electronic information – ***including an explicit description of the substance use disorder information that may be disclosed***: (Kind and/or extent of information to be released)

Dates/times of sessions and session notes as requested for billing/payment purposes

To be release for the following purpose(s):

****This is a requirement of the VA in order to have continued coverage of services****

I understand that the information I authorize for release may include records which may indicate the presence of a communicable or venereal disease, which may include but are not limited to, substance use or abuse disorders; diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS). **The release of information form has been explained to me and the consent has been given of my own free will.**

It has been explained to me that my treatment services are not contingent upon or influenced by my decision concerning the release of information.

_____

(Signature of client or legally authorized representative) Date

I request this Consent for Release to expire on _____ Client/Guardian Initials _____

_____

(Signature of staff requesting release) Date

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.