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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Important Notice: When you complete and sign this form, you authorize Positive Outcomes Therapeutic Services, LLC, its providers and staff to Release ❑ and/or Acquire ❑ information from another person or agency.

Client Full Name (Last, First, Middle Initial)	Date of Birth	Phone#	SSN#:
Mailing Address:			

Purpose of Release: _____

Type of Information to be released or obtained: _____

Records to be released between the dates of: **From Date** _____ **To date**_____

METHOD OF RELEASE: (choose all that applies / client must initial):
_____ Fax _____ Written _____ Verbal _____ Electronic (online, email or text) _____ Other

AGENCIES OR INDIVIDUALS TO BE RELEASED TO:

Name: _____ Relationship to client: Phone: Fax: Email: Address:	Name: _____ Relationship to client: Phone: Fax: Email: Address:	Name: _____ Relationship to client: Phone: Fax: Email: Address:

ACKNOWLEDGMENT OF UNDERSTANDING:

- I understand that my records are protected under state federal statutes regarding confidentiality and may not be disclosed without my written consent except in those situations detailed in the Informed Consent that I have previously signed.
- I understand the expiration date of this authorization is one year.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.
- I understand that in compliance with 76 Okla. Stat. Sec. 19, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records.
- I understand that my information authorized for release may include records relating to behavioral or mental health services and treatment of alcohol and drug abuse, the presence of communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, sickle cell, anemia, AIDS, HIV, or a positive diagnosis of a highly contagious SARS-CoV-2 also known as Novel Coronavirus (COVID-19).
- Written psychotherapy notes will NOT be released per provider policy and HIPAA privacy rules, 45 CFR Parts 160 and 164, 164.502 unless in the presence of a subpoena by the court.

_____	_____ _____	_____
Printed Name of Patient | Legal Guardian	Signature of Patient | Legal Guardian	Date signed
_____	_____ _____	_____
Relationship to the Patient	Signature of minor (14 yo and older)	Date signed