YOUTH AND FAMILY
Resource Center
Hope by another name

Welcome!

We're glad you're here. Taking this step is a powerful act of self-care, and we're honored to support you on your journey.

Our team is committed to providing a safe, supportive space where you can heal, grow, and thrive.

Please reach out anytime at (405) 275-3340 for assistance starting services at YFRC.

YOUTH AND FAMILY
Resource Center
Hope by another name

Informed Consent

Consent for Treatment Client initials:_____ Guardian initials:_____

I voluntarily agree to treatment and services from Youth and Family Resource Center. I understand the reasons for this treatment and the services recommended. I have received a copy of the Client Orientation Manual with my rights, responsibilities, and grievance/input procedures. I understand the manual presented to me.

HIV/AIDS/STD Education, Testing, and/or Counseling Client initials:_____ Guardian initials:_____

☐ **I want** education, testing and/or counseling for myself and a referral to my local health department.

☐ **I want** education, testing, and/or counseling for my significant other and a referral to my local health department

☐ **I do not want** education, testing, and/or counseling for myself.

☐ **I do not want** education, testing, and/or counseling for my significant other

Medication Management Client initials:_____ Guardian initials: _____

If I have prescribed medications I will provide consent for consultation with my physician. I further understand that Youth and Family Resource Center does not provide medication monitoring as a service and that I should consult my physician with all needs or concerns related to my prescribed medications.

Student Observations Client initials:_____ Guardian initials:_____

If I am or my child is enrolled in school I will provide consent for consultations with the appropriate school or teachers.

Confidentiality Client initials:_____ Guardian initials:_____

I understand my information is confidential. My information will not be released to other agencies or persons without my written consent except under a legitimate subpoena, in a medical emergency, to meet the legal requirements for reports of abuse to children or elders, or if I present a danger to myself or others. I have received information on legal requirements and limitations of mental health confidentiality.

Records Review Client initials:_____ Guardian initials:

I understand that my information may be reviewed by State agencies certifying receipt of services and/or compliance with requirements, or by accrediting agencies verifying the quality and completeness of the services I receive.

Follow-Up Client initials:_____ Guardian initials:_____

☐ **I agree** to be contacted after being discharged as a follow-up to learn my status, my progress in meeting my goals, my satisfaction with services, and other input about the services I received.

☐ **I do not agree** to be contacted after being discharged. The services I receive before being discharged are not dependent on my agreement for follow-up.

Client Name:_____ Date of Birth:_____ ID#_____

Emergency Contact

Name	Relationship	Address	Phone
_____	_____	_____	_____
_____	_____	_____	_____

Payment Source Release Client initials:_____ Guardian initials:_____

I understand agencies or other parties paying for my services may review my information or may require Youth and Family Resource Center to provide some or all of my information. I agree and hereby authorize Youth and Family Resource Center to release any of my information requested by agencies or parties paying for my services. I understand this specific consent for release of information ends only after third party payer claims are satisfied. All financial and insurance information provided will remain confidential and are only used for billing an reimbursement purposes.

I authorize the release of any medical or other information necessary to process an insurance claim. I understand that YFRC will diligently attempt to get accurate information regarding my mental health insurance benefits. I acknowledge I am responsible to know and understand my benefits plan. YFRC will file my insurance claims for me as a courtesy. I am ultimately responsible for all charges my insurance company does not pay, except for contacted network provider discounts that may apply. I also request assigned benefits be paid to YFRC and/or the provider indicated above.

Primary Insurance Information

Name of Policy Holder (Insured):_____

Insured SSN: _____ Insured DOB: _____

Relationship to Insured: _____

Insurance Company: _____

ID: _____ Group # : _____

Insurance Company Phone # : _____

I, the undersigned, give consent for treatment. I acknowledge that Youth and Family Resource Center policies stipulated above have been explained to me by Youth and Family Resource Center staff. I understand and agree to the above conditions.

_____ _____ _____ _____

Signature of Client Date Signature of Parent/Guardian Date

_____ _____ _____ _____

Signature of Witness Date Signature of Second Witness Date

Client Name:_____ Date of Birth:_____ ID#_____

Consent for Telehealth

Telehealth is the use of electronic information and communication technologies by a Mental Health Provider to deliver services

Consent for Telehealth Client initials:_____ Guardian initials:_____

I agree to participate and receive therapy via the use of a HIPAA compliant platform video telehealth delivery system. I will be receiving mental health services through interactive videoconferencing. I understand the use of videoconferencing is an alternative method of mental health care delivery and that my therapist will not be physically in the same room with me.

Termination Client initials:_____ Guardian initials:_____

I understand that I have the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which I am currently receiving or would otherwise be entitled. I understand that my participation in this is voluntary and I may decide to terminate my treatment at any time.

Advantages Client Initials _____ Guardian Initials _____

I understand that there are several benefits of receiving telehealth services that have been identified including increased access to specialized services in remote areas, lower healthcare costs, reduced travel, minimizing time off work, and decreased waiting time for services.

Disadvantages Client Initials _____ Guardian Initials _____

I understand that there are potential risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the therapist and Youth & Family Resource Center that the transmission of my telehealth session could be disrupted or distorted by technical failures. Furthermore, with telehealth, I understand there is the risk of being overheard by anyone near me if I do not place myself in a private area and protected from other's intrusion. I understand that I maintain sole responsibility for ensuring the privacy of my surroundings when participating in telehealth sessions. I also understand with any form of mental health services despite my efforts and the efforts of my therapist that my mental health issues may not get better.

Emergencies Client Initials _____ Guardian Initials _____

I understand that telehealth is not always appropriate for emergency medical and suicidal ideations and if such emergencies arise I will be required to seek face to face consultation and evaluation, and by signing this consent, I agree in advance to seek such care if I or my provider deem this necessary.

Confidentiality Client Initials _____ Guardian Initials _____

I understand that my privacy and confidentiality will be protected in the same manner if I were to receive therapy face to face with my therapist in the same room. I understand the laws that protect privacy in the confidentiality of medical information also apply to telehealth. As always, state agencies will have access to medical records for quality review/audit.

Client Name:_____ Date of Birth:_____ ID#_____

Recordings Client Initials _____ Guardian Initials _____

I understand that there will be no recordings of my therapy sessions. I also agree to not record my own therapy sessions without my therapist's knowledge or permission. I, the undersigned, give my consent to receive mental health services through a telehealth HIPPA compliant platform that I agree to use with my therapist. I also understand that the telehealth services I receive will become part of my mental health records.

I, the undersigned, give my consent to receive mental health services through a telehealth HIPPA compliant platform that I agree to use with my therapist. I also understand that the telehealth services I receive will become part of my mental health records.

Signature of Client	Date	Signature of Parent/Guardian	Date
Signature of Witness	Date	Signature of Second Witness	Date

Client Name:_____ Date of Birth:_____ ID#_____

YOUTH & FAMILY RESOURCE CENTER, INC.
Acknowledgements and Consent for Services/Treatment

Confidentiality: The policy of Youth & Family is to protect the confidentiality of clients and families at all times. This policy is in effect whether a request for information is verbal or written. The following policy is to be strictly followed.

Verbal information and information in client case files are kept in the strictest of confidence. Confidentiality is stressed in orientation and development programs for all employees and volunteers, regardless of program responsibilities.

Exceptions to Confidentiality: Client records are considered confidential and will not be released to other individuals or agencies without the expressed written consent of the client, unless:

1) the client discloses abuse;
2) the client intimates suicide;
3) the client states that he or she intends to break the law which may harm another person;
4) required by a court of competent jurisdiction pursuant to court order.

If a staff member ascertains that number 1 above has occurred, he or she is to report the suspected abuse first to Child Welfare and then to the CEO. Identifying information is not released to anyone except in accordance with the release of information policy of Youth & Family.

Since part of the cost of treatment may be paid by federal, state, or local sources, these sources have the right to review client files to verify that services have been delivered appropriately. This review is done for accounting or evaluative purposes only, with no files or clinical information removed from Youth & Family. Others having review access to your file are Youth & Family staff, consultants, and accountants on a need-to-know basis only.

☐ I/We (Parent, legal guardian if applicable) authorize the Youth & Family to administer treatment and to continue such treatment as deemed necessary.
☐ I/We hereby authorize medical, psychiatric, psychological, diagnosis or treatment by any physician, therapist or qualified mental health provider authorized by the Youth & Family.
☐ I/We understand that this consent is given before any specific diagnosis or treatment is required, but is given to authorize the Youth & Family to exercise their judgment in providing treatment.
☐ I/We agree to be actively involved in the treatment plan as prescribed by the Youth & Family treatment team while receiving treatment.
☐ I/We understand that included in this treatment plan would be involvement in regular family, individual or group therapy sessions.
☐ I/We have been given no guarantee by anyone as to the results that may be obtained.
☐ I/We consent to being contacted after discharge for the purpose of obtaining information in efforts to improve the quality of care (e.g., client satisfaction surveys, etc.).

THIS CONSENT SHALL REMAIN IN EFFECT COMMENCING ON THE DATE OF ADMISSION UNTIL FOLLOW UP IS COMPLETED, UNLESS REVOKED IN WRITING AND DELIVERED TO THE YOUTH & FAMLIY EXECUTIVE DIRECTOR.

Client	Date	Witness	Date
Parent/Guardian	Date		Date

Revised 7/27/17

YOUTH & FAMILY RESOURCE CENTER, INC.

Acknowledgements and Consent for Services/Treatment

MESSAGING INFORMED CONSENT

In order to communicate with you by text or email, we need to make sure you are aware of the confidentiality and other issues that arise when we communicate this way and to document that you are aware of these issues and agree to them. If you plan on communicating with your therapist through text or email, please sign the form below.

I understand that all e-mail messages sent over the internet by me or those affiliated with the Youth and Family Resource Center (YFRC) are encrypted. If e-mail communication is sent by a therapist or staff member, it will be limited to the minimum amount of communication necessary to meet the recipient's needs.

I hereby give permission for all my present and future YFRC therapists or staff to initiate text or e-mail contact with me or reply to my messages via text or e-mail and include any information that they deem appropriate, that would otherwise be considered confidential. I agree that the YFRC and any employees or agents of the YFRC shall not be liable for any breach of confidentiality that may result from this use of e-mail via the internet or texting by cell service. I understand that texting or e-mail communication should not be used for urgent or sensitive matters since technical or other factors may prevent a timely answer. I understand security encryption is not available for cell phones and texting. If I believe I need a response within 48 hours, I will not use text or e-mail but will call my therapist. If I do not receive an answer to a routine e-mail message within three working days, I understand that I should call my therapist. I understand that while I may request electronic communication, the therapist is not obligated to respond electronically if there are any concerns about the legitimacy of the e-mail query or the identity of the e-mail correspondent.

I understand that all e-mail communications may be documented and/or made part of my permanent clinical record and would be accessible to all current and future YFRC therapists and staff involved in my care. YFRC will use text messaging to cell phone numbers provided to the practice for purposes of appointment reminders.

I understand YFRC contacts via phone to cancel, remind, schedule or reschedule appointments. I understand I can grant or deny voicemails being left by YFRC Staff at any time throughout my treatment.

I understand YFRC may contact via mail for various documentation purposes.

If child is a minor or patient is unable to sign, then legal guardian of child will sign for the patient.

I also understand that I may withdraw permission for therapists to communicate with me via texting and e-mail by notifying my therapist in writing.

Patient Name: _____
Signature of legal guardian: _____
Print Name of legal guardian: _____
Relationship of legal guardian: _____
Cell Phone Number: _____
Email Address: _____
Date: _____
Witness: _____

I consent to the following type of messaging:

- ☐ Text messaging
- ☐ E-mail
- ☐ Voicemails
- ☐ US Postal Mail

Revised 7/27/17

CONSENT FOR AUTOMATED TEXT MESSAGE AND EMAIL APPOINTMENT REMINDERS

Youth and Family Resource Center (YFRC) offers automated text message and email reminders for upcoming appointments to clients. These reminders are sent through a third party system called Text Belt that works with our HIPAA compliant Electronic Health Record (EHR).

The automated text and email reminders will only include the name of your provider and the time of your appointment. If you need any additional information about your appointment, you can call the office at 405-275-3340. YFRC will not currently be able to receive a response to the automated text message or email reminders that are sent to you.

Please indicate below whether or not you consent for YFRC to send automated text messages, emails, or both communication methods through Text Belt to remind you about your upcoming appointments. This consent is different from your Messaging Informed Consent signed at Intake. The Messaging Informed Consent form that you filled out at Intake indicates whether or not you give YFRC staff permission to text, email, or leave voicemails for you regarding your services. If you selected to receive text messages or emails on your Messaging Informed Consent form at Intake and wish to receive automated appointment reminders, you must also fill out this form since it relates to a different messaging system.

The automated text message or email reminders must be sent to you or a legal guardian. You will be asked to include the preferred phone number and/or email address through which you wish to receive these communications, if you choose to do so.

Please indicate below which methods you consent to receiving automated reminders through Text Belt about your upcoming appointments:

☐ Text Message

☐ Email

☐ Text Message and Email

☐ None

Preferred Phone Number: _____

Preferred Email Address: _____

I certify that the contact information listed above belongs to myself or my legal guardian. I understand that I can withdraw my consent at any time by updating this form with a YFRC staff member. I understand that my cell service provider may charge additional fees if I do not have a text messaging feature on my phone plan.

Client Signature _____ Date _____

Staff Witness _____ Date _____

Youth and Family Resource Center
326 W 11th Street,
Shawnee, OK 74804

Phone: 405-275-3340
Fax: 405-275-3343

Clinical Services and Counseling Fee Agreement

YFRC's services are funded through a combination of grants, private donations, and Medicaid funding. While funding is available, services are provided at no cost to clients. If funding becomes unavailable or is exhausted, the Sliding Fee Scale—based on reported annual gross household income—will apply. YFRC staff will explain the scale and discuss available payment options at least 30 days before payment for services is expected. Payment for services, if applicable, will be due prior to each session. No one will be denied services due to inability to pay.

The financial information I provide is true and complete to the best of my knowledge. I will inform YFRC staff of any changes to my household or insurance that might impact reimbursement for services. I agree to pay all charges incurred by me and/or my family members. I understand that I am responsible for any bank fees incurred due to returned checks.

_____ _____

Client Name *Date*

_____ _____

Client Signature *Date*

_____ _____

Parent or Legal Guardian (if under 18) Signature *Date*

_____ _____

YFRC Staff Signature *Date*

Notice of Privacy Practices

This notice describes how medical and mental health information about you may be used and disclosed and how you can get access to this information. Please read carefully

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about your privacy practices, our legal duties, and your rights concerning your health information. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we can maintain at that time. In the event that the notice is changed a new notice will be sent to you by mail or at the time of your next appointment. You may request a copy of our Notice at any time.

This notice takes effect now and will remain in effect until we replace it.

Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

You will be asked to sign a consent form. Once you have consented to the use and disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, this agency will use or disclose your protected health information as described below.

Treatment: We may use and disclose, as needed, your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information.

Payment: We may use and disclose, as needed, your health information to obtain payment for services we provide to you. This may include certain activities that your insurance plan my undertake before it approves or pays for the mental health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you and undertaking utilization review activities.

Healthcare Operations: We may use and disclose, as needed, your health information in connect with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of mental healthcare professionals, evaluating practitioner and provider performance, employee review activities, conducting training programs, accreditation, certification, licensing or credentialing activities, and conducting or arranging for other business activities.

Uses and Disclosures of protected Health Information Based upon your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in the Notice.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. In the event of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. If this occurs, the agency will try to obtain your consent as soon as reasonably practicable after the delivery of treatment.

Other permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required by Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes, to a public health authority that is permitted by law to collect or receive information.

Health Oversight: We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected information, so long as applicable legal requirements are met, for law enforcement purposes.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, or counterintelligence, and other national security activities. We may also disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or client under certain circumstances.

Appointment reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters)

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et.seq.

Client Rights

Access: You have the right to inspect and copy your protected health information. You may requires that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must submit your request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information at the end of this notice. We will charge a reasonable cost-based fee for expenses such as copies and staff time. If you request copies, we will charge you $0.15 for each page, and $20.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

Restriction: You may have the right to request a restriction of your protected health information. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. If we agree to the additional restrictions we will abide by our agreement (Except in an emergency).

We are not required to agree to a restriction that you may request. If we believe it is in your best interest to permit use and disclosure of your protected health information, your protected information will not be restricted.

Alternative Communication: You have the right to request to receive confidential communications from us by alternative means at an alternative location. You must make your request in writing. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact.

Amendment Request: You have the right to request that we amend your protected health information. Your request must be in writing and explain why the information should be amended. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Disclosure Accounting: You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices.

Notice: You have the right to obtain a paper copy of this notice from us upon request.

Questions and Complaints

You may complain to us or the Secretary of Health and Human Services if you believe your privacy right shave been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We support your right to the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

You may contact our Privacy officer below for further information about the complaint process.

Privacy Officer: Joani Webster
Phone Number: 405-275-3340
E-Mail: joaniw@yfrcshawnee.org

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT FORM

Client Last Name: _____ First: _____

ID#_____

I, _____, have read and received a copy of Youth & Family Resource Center, INC. Notice Privacy Practices.

_____ _____
(Client Signature) Date

_____ _____
(Parent/ Legal Guardian Signature) Date

_____ _____
(Staff Signature) Date

_____ _____

CLIENT HANDBOOK ACKNOWLEDGEMENT

I have received and reviewed the contents of the YFRC Client Handbook. Contents includes but is not limited to: Client Bill of Rights, Rights to Confidentiality, Ethical Responsibility, Code of Ethics, Provider Responsibility, process for grievances, ODMHSHS contact information, Client Safety, Right to Name a Treatment Advocate, Smoking Policy, Involuntary Termination of Services, AIDS/STD/TB Education.

_____ _____

Client Signature Date

ORIENTATION PACKET INCLUDES FOLLWONG DOCUMENTS:

Mission Statement
Hours of Operation
Access to Services
Admission/Re-Admission
Client Rights & Responsibilities
Loss of Privileges or Rights
Means to Regain Privileges or Rights
Program Rules
Program Description
Therapeutic Options
Notice of Privacy Practices Acknowledgement Form
Non-Discrimination Statement
Fees for Service
Individual Plan Development L
Discharge/Transition Plan Description
Code of Ethics
Client's Rights
Client Grievances & Issues
Confidentiality
Appointment Cancellation Procedure
Client Health & Safety Orientation
Vehicle/Transportation Policy

FOR INTERNAL OFFICE USE ONLY

☐ Acknowledgement received by_____ on _____

☐ Acknowledgement refused by client and treatment refused as permitted.

Youth and Family Resource Center, Inc.

326 W. 11th Shawnee, OK 74801 (o) 405-275-3340 (f) 405-275-3343

CONSENT/PRIVACY AUTHORIZATION FORM FOR RELEASE OF INFORMATION

I understand that records are protected under Federal and State Confidentiality Law and Regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations.

I/We hereby authorize **Youth and Family Resource Center, Inc.** to disclose and receive the following protected health information regarding:

Name of Client: _____ D.O.B. _____

To:

Name: _____

Address: _____

Phone: _____ Fax / Email: _____

Specifically describe the information to be disclosed:

☐ Assessment / Evaluation
☐ Treatment plans
☐ Progress notes
☐ Discharge summaries
☐ Medication information
☐ Psychological testing
☐ Appointment attendance
☐ Other (specify): _____

This protected health information is being disclosed for the following purposes:

☐ Continuity of care / treatment coordination
☐ Insurance / billing
☐ Legal
☐ Personal use
☐ Other: _____

Method of Disclosure:

☐ Verbal ☐ Written ☐ Electronic ☐ Fax

Client Name_____ Client DOB_____ Client ID_____

I also understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it, and that in any event this authorization expires automatically as follows:_____ , or if unspecified, one (1) year after the patient's dated signature (below). Revocations should be submitted to the Privacy Officer or Clinical Director where the information and appropriate revocation forms are kept. I understand that my records are currently protected by Oklahoma State Statutes and federal privacy regulations including the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 & 164. I understand that my health information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may redisclose the information and it may no longer be protected by the HIPAA privacy law. I understand that the covered entity and/or program seeking this authorization will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I freely and voluntarily give this consent. I understand that I am entitled to receive a copy of this authorization after it is signed.

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE. (63 O.S. 1-502.2.B, eff. 11/1/2007)

This authorization shall be in force and effect on date signed for 1 year from date signed or until discharged, at which time this authorization to disclose this protected health information expires.

I, _____ REVOKE AUTHORIZATION OF RELEASE OF INFORMATION. PLEASE SIGN AND DATE BELOW:

_____	_____	_____	_____
Client Signature	Date	Clinician Signature	Date

Re: Drug/Alcohol Abuse Records – Confidentiality of drug/alcohol abuse records is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit making any further disclosure of this information unless further disclosure is expressively permitted by 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 an alcohol/drug abuse patient.

Do you authorize the release of substance use disorder records?

☐ **YES**, I authorize disclosure of substance use disorder records protected by 42 CFR Part 2

☐ **NO**, I do NOT authorize disclosure of these records

If YES, list any limitations:

_____	_____
Signature of Client	**Date**
_____	_____
Parent/Guardian Signature (required if under age 18)	**Date**
_____	_____
Staff/Witness	**Date**

Client Name_____ Client DOB_____ Client ID_____