

**Cleary Counseling and Consultation, Inc.**  
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## CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, \_\_\_\_\_  
(NAME OF PATIENT)

\_\_\_\_\_  
(DATE OF BIRTH)

\_\_\_\_\_  
(SOCIAL SECURITY NUMBER)

Hereby authorizes Jacquyn Cleary/Cleary Counseling and Consultation, Inc. to:

Check one: \_\_\_\_\_disclose to \_\_\_\_\_obtain from

\_\_\_\_\_  
(NAME OF PERSON)

\_\_\_\_\_  
(NAME OF ORGANIZATION)

\_\_\_\_\_  
(ADDRESS OF PERSON OR ORGANIZATION: CITY, STATE, ZIP CODE AND TELEPHONE NUMBER)

Information pertaining to my medical care and treatment including psychiatric, substance (drug and alcohol) abuse, and communicable disease. Information required:

_____ Termination/Discharge Summary	_____ Therapist Evaluations
_____ Psychiatric/Psychological Evaluations	_____ Progress Notes
_____ Medical History	_____ Psychological Assessment
_____ Treatment	_____ Psychological Testing
_____ Other (Specify) _____	

## **PAGE 2 RELEASE OF INFORMATION**

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The information authorized for release may include records that may indicate the presence of communicable or non-communicable disease, including but not limited to diseases such as venereal disease, hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS).

**NOTICE TO PATIENTS:** Information in your medical record that you have or may have a communicable or venereal disease is made confidential by law and cannot be released without your permission except in limited circumstances including release to persons who have had risk exposures, release pursuant to an order of the court or the Department of Health, release among health care providers, or release for statistical or epidemiological purposes. When such information is released, it cannot contain information from which you could be identified unless release of that identifying information is authorized by you, by an order of the court or the Department of Health, or by law.

**PROHIBITION ON RE-DISCLOSURE/DRUG/ALCOHOL ABUSE RECORDS:** 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 alcohol or drug abuse patients.

**PSYCHIATRIC RECORDS:** Oklahoma State Law (76 OS Section 19) provides that psychological or psychiatric records may not be provided to a patient, their guardians or agents, without consent of the treating physician or practitioner or an order from a courts of competent jurisdiction upon finding that it is in the best interest of the patient.

I understand that my right to confidentiality under Federal law and regulations does not protect any information about suspected child abuse or neglect. In addition, if there is any reason to suspect that I am in danger of physical or bodily harm, or that anyone else is in danger of physical or bodily harm, that this information is not protected under Federal regulation.

Please be advised that referral sources, especially employers or their designated Employee Assistance Representative, who have an interest in your treatment and ongoing recovery may request information about your current and/or continuing care. This information can only be released with appropriate authorization by you. However, failure to authorize such release may impede a productive relationship with your referral source without implication of liability on the part of Jacquyn Cleary/Cleary Counseling and Consultation, Inc.

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I understand this authorization is subject to revocation by me at any time except to the extent that action has already been taken in reliance on it. With this knowledge, I give consent to the release of information in my medical records including any information concerning my identity and I release Jacquyn Cleary/Cleary Counseling and Consultation, Inc. its agents and employees from any liability in connection with the release of the information contained herein.

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**Client Signature**

**Date**

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**Parent or Guardian Signature if patient is a minor**

**Date**

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**Witness Signature**

**Date**

**Approval by physician/clinician to release records to patient:**

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**Physician/Clinician Signature**

**Date**