Roberts Group Counseling

Consumer Name _____

Identifier _____

Consent for Release of Confidential Information

I, _____ _____ _____

Name DOB SSN

I authorize The Roberts Group Counseling, LLC. and the following agencies, entities, or people to release and disclose to one another the following types of information:

Information released or disclosed will be used to coordinate, evaluate, plan and/or continue appropriate treatment or program, determine eligibility for benefits or program, case review, and/or update files. Released information may be subject to re-disclosure by the recipient, resulting in the information no longer being protected.
This consent is valid from:

(Start Date) _____ to (end date) _____ (One year period minus one day)

Each individual organization requires separate form.

Release info to or from (List specific person(s), title/position, and address):

Name(s): _____

Address: _____

_____

Purpose of release (be as specific as possible): _____

_____

_____

Items to be released (be as specific as possible): _____

_____

_____

I understand my medical records and all clinical information are confidential and are protected under the provisions of 43A OS & 1-109. I understand medical records and all communications between consumer and doctor or psychotherapist are privileged and confidential; with such information limited to persons or agencies actively engaged in my treatment or related to administrative tasks. I understand privileged and confidential information shall not be released without my written, informed consent. I understand that treatment is not contingent upon or influenced by my decision to permit this information release. My consent is given freely and voluntarily. **The information authorized for release may include records, which may indicate the presence of a communicable or non communicable disease, 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. SEC. 1-1502(B)). If any criminal proceeding is involved, disclosure is bound by federal laws and regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 U.S.C. #290DD-2; 42 C.F. R., Part 2) and recipients of the information may receive and disclose it only in connection with their official duties with respect to the particular criminal proceeding and may not use the information in other proceedings, for other purposes, or with respect to other individuals.** I understand that I may revoke this consent in writing at any time by signing and dating the revocation line at the bottom of this page, except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically one year following the date I stopped receiving services from The Roberts Group Counseling, LLC. Revocation must be submitted to your therapist. However, if any criminal proceeding is involved, this consent is irrevocable until final disposition of the proceeding, and expires upon final disposition of the proceeding.

Signature: _____ Date _____

Parent/Guardian Signature: _____ Date _____

Legally authorized Representative: _____ Date _____

I hereby revoke this consent: _____ Date _____

Witness Signature: _____ Date _____