Lucy Wilson, LCSW
4823 S. Sheridan Suite 315
Tulsa, OK 74145
(918) 574-2722

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

_____ _____ _____
(Name of patient) (date of birth) (social security number)

I hereby authorize **Lucy Wilson, LCSW**. _____ to disclose to _____ to obtain from:

_____
Person(s) Organization

_____
Address City State Zip Phone

information pertaining to my medical care and treatment including psychiatric, drug abuse and /or alcoholism records or communicable disease. Information required:

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

This consent is for the period: ___ A. Beginning _____ and ending _____.
___ B. Duration of Treatment.
___ C. _____ months after patient signature.

The information authorized for release may include records which may indicate the presence of a 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 of 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 REDISCLOSURE/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 any alcohol or drug abuse patient.
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PSYCHIATRIC RECORDS: Oklahoma State Law (76 O.S. 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 court 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 reason to suspect that I am in danger of physical or bodily harm, or that any one 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, a failure to authorize such release may impede a productive relationship with your referral source without implication of liability on the part of **Lucy Wilson, LCSW.**

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 release **Lucy Wilson, LCSW** her agents and employees from any liability in connection with the release of the information contained therein.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent of Guardian if patient is a minor Date

_____ _____

Witness Date

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

(Clinician Signature) (Date)