Broken Arrow, OK
8937 South Garnett Road, 74012
Phone: 918-872-9777 Fax: 918-872-9779

Claremore, OK
2990 North Sioux Road, 74017
Phone: 918-342-2622 Fax: 918-342-2641

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

PAITENT NAME_____ DOB_____

Please check ONE below:

____ I **REFUSE** to give authorization for any release of information

____ I authorize Strength of Mind (SOM) to communicate regarding the above-named client with the following individual or agency. This authorization will allow SOM to share protected health information (PHI). This PHI may include diagnosis, treatment plan, progress, and medication, if necessary.

Provider/Entity:_____ Phone:_____ Fax:_____

Address:_____ City:_____ State:_____ ZIP:_____

Other Name/Relation:_____ Phone:_____ Fax:_____

Address:_____ City:_____ State:_____ ZIP:_____

Disclousure may include the following verbal or written information: (check all that apply)

____Demographics

____Copy of complete medical record

____History & Physical

____ Psychosocial assessment

____Psychological testing results

____Medication records

____ Summary of treatment records & contact dates

____All of the above

_____Other (specify)_____

I understand that these records are protected by federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request.

Signature: _____ Date: _____
(Patient, Parent, or Legal Guardian)

EXPIRATION: This authorization will expire on (date or event):_____

If no date or event is specified, the authorization shall expire 30 days after the end of treatment.