P S Y C H O S O C I A L E V A L U A T I O N

RELEASE OF CONFIDENTIAL INFORMATION

INFORMATION TO BE RELEASED FROM

Legacy Family Services, Inc. **4501 Classen Blvd , Suite 105, Oklahoma City, OK, 73118** **(405) 202-1027**

CLIENT INFORMATION

Name of client: Date:

Date of birth:

Guardian/Parent's name:

PLEASE RELEASE INFORMATION TO

Name or company/agency/school:

Address: Phone Number :

PURPOSE FOR THE DISCLOSURE

DESCRIPTION OF INFORMATION TO BE RELEASED

- I understand that once information is disclosed pursuant to this authorization that the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 and 164, protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit re-disclosure.
- I understand that generally the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition my treatment, payment, or eligibility for health care benefits on my decision to sign this authorization. I am signing this release freely and voluntarily.
- I understand that I (or my legally authorized representative) may revoke this authorization in writing at any time except to the extent that on has been taken in reliance on it, or unless this authorization is given as a condition of obtaining health insurance coverage and the insurer has a legal right to contest the policy or a claim under the policy. To revoke this authorization, I will provide the above listed agency's office with a written revocation.
- I understand that I have the right to inspect the health information I have authorized to be used or disclosed by this authorization form.
- I understand that if I agree to sign this authorization, I must be provided with a signed copy of this form if I so request.
- **I understand that the information in my record may include information relating to treatment of drug or alcohol abuse, psychological or psychiatric impairments, sexually transmitted illnesses, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC), human immunodeficiency virus (HIV), or other communicable or non-communicable disease.**
- I understand that unless I provide a written revocation at an earlier date, this authorization will expire in one year or when this release is no longer reasonably necessary to serve the purpose for which it is given.
- I understand treatment services are not contingent upon or influenced my decision to permit the information release.

Client Signature (if 18 or older) **Date**

Parent/Guardian Signature **Date**

Clinician **Date**