COMMANDER

COUNSELING & WELLNESS

Request for an Individual's Health Information / Treatment Records and Authorization to Release

Last:	First:	Middle:
Other Names Used:	Date of Birth:	SS#:
Address:		
Home Phone: ( )	Work Phone: ( )	

☐ I hereby request access to the protected health information in my health record or, if I am a student, my treatment record, until (date) _____.

[ ] Session Attendance Record
[ ] Psychological Testing
[ ] Discharge Summary
[ ] Psychiatric Evaluation
[ ] I will pick up the copies of my records

[ ] Medications
[ ] Treatment Plans
[ ] Diagnosis
[ ] Other: _____
[ ] Mail copies of my records to the individual noted below :

Records To / From:	Records To / From:
Name: Commander Counseling & Wellness	Name:
Address: 3351 W Rock Creek Rd, St 120, Norman OK 73072	Address:
Phone: 405-801-2840	Phone:
Fax: 405-701-5950	Fax:

Purpose of Request: __patient's request, __dispute, __referral, __other: _____

I understand:

- I may revoke this authorization at any time by providing my written revocation to Commander Counseling & Wellness. My revocation will not apply to information already retained, used or disclosed in response to this authorization. Unless revoked, the automatic expiration date will be six (6) months from the date of signature.
- Student treatment /education records may retain continuing privacy protections in accordance with 34 C.F.R. Part 99.
- **THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS THAT MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE.**
- The information authorized for release also may include protected health information or treatment or education records related to mental health.
- The information authorized for release also may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by the written authorization 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. As a result, by signing below I specifically authorize any such records included in my health information to be released.
- I understand that if my records are released that I will be charged $1.00 for the first page and $0.50 for each subsequent page for paper records and $5.00 per film for radiology film, plus postage payable prior to the release of the requested records. (Make all checks payable to _____ (fill in)). These fees have been set by the Oklahoma state legislature.

_____ _____ _____

Signature of Patient, Parent, or Legal Representative | Relationships to Patient | Date