GREAT PLAINS YOUTH & FAMILY SERVICES, INC.

901 S. BROADWAY
HOBART, OKLAHOMA 73651

580.726.3383
FAX: 580.726.3384

WWW.GPYFS.ORG

CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO NON-TREATING PARTIES

1. **AUTHORIZATION**: I hereby authorize the use or disclosure of protected health information about me as described below.

Client: _____
(Last Name) (First Name) (Middle Name) (Maiden Name)

Date or Birth: _____ Social Security Number: _____

Address: _____
(Street) (Apt #) (City) (State) (Zip)

Authorize: [ ] GPYFS or [ ] Other _____

To exchange information with: _____
(Specific description of person(s) and/or Organization)

2. **INFORMATION TO BE USED OR DISCLOSED:** (Please initial next to the information to be used or disclosed.)

[ ] Diagnosis	[ ] Psychiatric Evaluation	[ ] Medication(s)
[ ] Results of Psychiatric Testing	[ ] Assessment Information	[ ] Communicable Disease Information
[ ] Treatment Planning Information	[ ] Reason for Termination	[ ] Progress & Treatment Notes
[ ] Number of kept/unkept appointments	[ ] Recommendations	[ ] Other: _____

3. PURPOSE OR NEED FOR USE OR DISCLOSURE: (Please initial next to the reason for use or disclosure.)

[ ] Collaboration with School	[ ] To comply with Court Order	[ ] Emergency Contact
[ ] For client treatment	[ ] Other: _____	

4. THIS INFORMATION MAY BE SHARED BY:

[ ] Verbally [ ] Fax [ ] E-mail [ ] Telephone [ ] Documents sent by e-mail

[ ] I request GPYFS make copies of my medical records. I understand that these records contain protected health information (PHI). I agree to be responsible for the cost of copying these records, including copying fees, labor, supplies, and postage (if applicable). The charge for this will be $0.10 per page and I will be charged a minimum of $2.00. I agree to pay for this prior to the service being rendered.

5. THIS AUTHORIZATION WILL EXPIRE AS NOTED BELOW:

[ ] At the end of 60 days [ ] At termination of my treatment

[ ] At the happening of the following event or date: _____

6. I understand that I may revoke this authorization by completing Part 10 below. However, I understand that if I revoke this authorization, it will not have any effect on actions already taken by GPYFS in reliance on this authorization.

7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits.

8. **The information authorized for release may include information that may indicate the presence of a communicable or venereal disease that my 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).**

9. I understand that my records are protected by federal and state laws and cannot be disclosed without my written permission, except as noted in GPYFS Notice of Privacy Practices. I UNDERSTAND THAT THIS RELEASE ALSO INCLUDES ANY REFERENCE TO DRUG AND/OR ALCOHOL TREATMENT AS PROTECTED BY FEDERAL LAW.

_____ _____ _____
(Signature of Client or Representative) (Date of Signature) (Witness Signature)

_____ _____
(Printed Name, if Client's Representative) (Description of Representative's Authority to Act for Client, i.e. Relationship)

10. REVOCATION: I wish to revoke this authorization: _____ Date: _____
(Signature of Client or Representative)

Person witnessing revocation: _____ Date: _____

NOTE: The receiving individual or organization understands that it IS NOT TO RE-RELEASE any of the confidential information received. Once the information is used and/or disclosed by GPYFS, it is no longer protected by the federal privacy regulations and may be subject to re-disclosure by the recipient.

Client: Last Name _____ First _____ MI _____

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REQUEST FOR RELEASE OF INFORMATION

I, _____, understand that GPYFS has 48 hours to respond to a request for information.

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Response to Request

_____ **Grants** all or part of your request

Request **Granted** by: _____ Date: _____

_____ **Denies** all or part of your request for the following reason(s):

- _____ not part of your designated record set
- _____ contains psychotherapy notes
- _____ information was compiled for civil, criminal, or administrative actions
- _____ regards inmate at correctional institution
- _____ was created during research
- _____ is subject to Federal privacy act
- _____ was not created by this Agency

Client may not appeal if denial is for any of the above reasons

_____ **Denied** at the discretion of GPYFS as the information may be harmful to the client or a third party

_____ Requests a 30-day extension to respond due to _____.

Request **Denied** by: _____ Date: _____

Acknowledgement of Receipt of Records

Attach Certified Receipt or Sign if picked up in person

I acknowledge receipt of records for _____ (client name).

Signature: _____ Date: _____

Witness Signature: _____ Date: _____