Charles F. McGowen, LCSW
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Licensed Clinical Social Worker
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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I hereby authorize and request Charles McGowen, LCSW To ____ Release To
____ Obtain From

_____
Name Address

_____ _____
Phone Number Fax Number

pertinent confidential information regarding_____
Name Date of Birth

State and federal regulations restrict the distribution of mental health and substance abuse records. Federal rules prohibit the recipient from making any further disclosure of this information unless expressly permitted by written consent or as otherwise provided by law. A general authorization for the release of medical or other information is not sufficient for this purpose (42 CFR Part 2)

All records and communications between patient and counselor are both privileged and confidential. Such records may only be released upon written authorization by the patient or legal guardian or as otherwise provided by law. Oklahoma law states that mental health treatment records may be released to a patient or legal guardian only in response to a court order or after the treatment provider certifies the release is in the best interest of the patient. A patient or legal guardian may authorize release of records to an attorney or other third party, but that authorization does not permit the patient's personal access to such records. (43A OS, Sec 1-109; 76 OS, Sec 19)

The Information authorized for release may include records which may indicate the presence of a communicable or noncommunicable disease.

Information to be Released: _____

_____

_____

Purpose of Disclosure:_____

This authorization will expire the later of _____ or no more than 1 year after signing.

I release the parties named above from liability arising from disclosure pursuant to this authorization. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. I certify that I have the required legal standing for myself or, in the case or a minor child, have legal custody and/or other required legal right to authorize the release of confidential information. A copy of this authorization is to be considered as valid as the original.

_____
Signature Date

_____
Relation to Patient

_____
Witness Date