tulsacares

Consent for Exchange of Confidential Information

READ FIRST: Before you decide whether or not to let Tulsa CARES share or request some of your confidential information with another agency or person, your Care Coordinator will discuss with you all alternatives and any potential risks and benefits that could result from sharing your confidential information. If you decide you want Tulsa CARES to release or request some of your confidential information, you can use this form to choose what is shared, how it's shared, with whom, and for how long.

I understand that Tulsa CARES has an obligation to keep my personal information, identifying information, and my records confidential.

I also understand that I can choose to allow Tulsa CARES to release or request some of my personal information to certain individuals or agencies. **I, _____, authorize Tulsa CARES to release or request the following information to/from:**
Client Name / D.O.B.

Who I want to have my information:	**Name:** Authorized OSDH Ryan White Program Personnel **Email Address:** VernaM@health.ok.gov, Verna Meadows, Sherrie Felty, Cindy Boerger SherriF@health.ok.gov, CindyB@health.ok.gov **Address:** 1000 NE 10th Street Oklahoma City, Oklahoma 73117-1299 **Specific Office at Agency:** Division of Care Delivery HIV/STD Service, Oklahoma State Department of Health **Phone Number:** 405-271-9444 **Fax Number:** 405-271-3412

The information may be shared: ☐ in person ☐ by phone ☐ by fax ☐ by mail ☐ by e-mail
☐ *I understand that electronic mail (e-mail) is not confidential and can be intercepted and read by other people.*

What information about me will be shared between Tulsa CARES and this provider:	☐ Proof of HIV Status ☐ Medical Records, including CD4 and Viral Load laboratory reports ☐ Financial or Income Documentation ☐ Case Management Notes / Service History ☐ Mental Health Records ☐ Other: _____
Why I want my information shared: (purpose)	☐ Ongoing for continued services (valid for no more than 365 days*) ☐ One-time only for a one-time purpose (valid for no more than 90 days*) Specify one-time only purpose: _____

Please Note: There is a risk that a limited release of information can potentially open up access by others to all of your confidential information held by Tulsa CARES.

I understand:

☐ That I do not have to sign this release form. I do not have to allow Tulsa CARES to share my information. Signing a release form is completely voluntary. This release is limited to what I write above. If I would like Tulsa CARES to release information about me in the future that is different from what is authorized here, I will need to sign another written, time-limited release.

☐ That releasing information about me could give another agency or person information that would confirm I have been receiving services from Tulsa CARES. Information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.

☐ That Tulsa CARES and I may not be able to control what happens to my information once it has been released to the above person or agency, and that the agency or person getting my information may be required by law or practice to share it with others.

☐ The confidentiality of drug/alcohol abuse records is protected by federal law. Federal regulation (42 C.F.R. Part 2) prohibits the agency listed above from making any further disclosure of records without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. I also understand that Oklahoma State Law (76 O.S.Supp.1986.Section 19) states that psychological or psychiatric records may be provided to a patient only if the treatment physician or practitioner consents to the release or upon receipt of a court order issued by a court of competent jurisdiction.

This release expires on: _____ _____
Date Time

Expiration should meet the needs of the client, which usually ranges between 90 days to 365 days. Authorization cannot exceed 365 days.

I would like a copy of this signed consent. ☐ Yes ☐ No

I understand that this release is valid when I sign it and that I may withdraw my consent to this release at any time either orally or in writing.

Date:_____

Signed:_____ **Time:**_____ **Witness:**_____