OSU Employee Assistance Program (EAP) Psychological Services

Oklahoma State University Health Services 1202 W. Farm Rd, Stillwater, OK 74078 405-744-7665

Authorization to Release Information

I, _____, authorize the OSU EAP Psychological Services to:

[ ] disclose information to [ ] receive information from [ ] exchange information with

Name/Title: _____

Agency (if applicable): _____

Phone: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip: _____

The information to be disclosed is:	
[ ] Intake report [ ] Psychosocial history report [ ] Summary of treatment and progress [ ] All treatment records [ ] Discharge summary	[ ] Psychodiagnostic assessments/reports [ ] Attendance/Participation in treatment [ ] Psychiatric evaluation/Medication history [ ] Treatment recommendations [ ] Other (specify):_____

The purpose of this disclosure is for:	
[ ] Further treatment/Coordination of care [ ] Family/Support system involvement [ ] Evaluation/Assessment [ ] Treatment planning	[ ] At my request [ ] Condition for return to work [ ] Other (specify):_____

Expiration of consent:
This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event (specify if applicable or leave blank): _____

I understand that I have the right to revoke this consent at any time, except for instances in which information has already been released, by written notification made to OSU EAP Psychological Services. I have been informed about my rights to confidentiality and privacy. I understand the ways in which the presence or absence of my consent to release information could impact my ability to receive treatment. I understand that this consent is voluntary and I agree to the release of information as specified.

_____ _____

Client name **CWID or date of birth** **Date**

_____ _____

Signature of client or legal guardian **Date**

This is a strictly confidential client record. Redisclosure or transfer is prohibited by law.