

Authorization for the Release of Healthcare Records

Patient Name: _____ Date of Birth: _____
(also list maiden name/other names used)

I hereby request and authorize:

Family Therapy and Renewal Center, PLLC
6717 S Yale, Suite 202
Tulsa, OK 74136

_____ **To Disclose information to:** _____ **To Receive Information from:**

Provider: _____

Address: _____

City/State/Zip _____

Information to be disclosed include copies of:

_____ Entire Record

_____ Progress Notes

_____ Other: _____

This authorization will be effective for one year after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.

Signature of Patient Date: _____

OR

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

Signature of Legal Representative/Relationship Date: _____

Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.