AUTHORIZATION FOR RELEASE AND RECEIPT OF RECORDS AND INFORMATION

This form, when completed and signed by you, authorizes me to release protected health information from your clinical record to the person designated.

____________________ **(Client/Childs Name If Applicable)**

I, ____________________, hereby authorize **BOTH THE RELEASE AND RECEIPT** of information and records which may include clinical opinions between my therapist:

____

Of

Oklahoma Christian Counseling Center

13301 N. Meridian, Bldg 100

Oklahoma City, OK 73120

AND

____

(Name of physician, counselor, psychologist, attorney, etc.)

____

Address City State Zip

This information should be released only to the above named person(s). The following is a specific description of the information that I want disclosed: ____________________

____

I am requesting my therapist to release this information for the following reasons: ("at the request of the individual" is all that is required if you do not desire to state a specific purpose.) ____________________

____

This authorization shall remain in effect until __________ or until ____________________

Expiration Date Description of event that relates to

____

the individual or the purpose of the use or disclosure.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to my therapist's office address. However, my revocation will not be effective to the extent that my therapist has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my therapist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of this information and thus is no longer protected by the HIPAA Privacy Rule, nor is this Oklahoma Christian Counseling Center therapist responsible for such redisclosures by the recipient named in this release.

Oklahoma State Law (O.S. 63 Sec. 1-5022) requires the following statement; The information authorized for release may include information which may be considered information about communicable or venereal diseases which include, but are not limited to diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome.

____________________ ____________________

Signature of Client or Client's Representative Date

(If signed by a representative, a description of such representative's Authority to act for the client must be provided.)

____________________ ____________________

Signature of Witness Date