THERAFUNCTION

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

_____	_____	_____
Name of Client	Date of Birth	Name of Parent

I hereby authorize: _____

To obtain from/ or

Release to: _____

The following information: _____

For the purpose of: _____

This consent expires: _____

I understand that my records are protected under state federal statutes regarding confidentiality and may not be disclosed without my written consent except in those situations detailed in the Informed Consent that I have previously signed. I also understand that I may revoke this consent at any time except to the extent that action has already been taken based upon it.

NOTICE

(63 O.S. Supp. 1992, 1-502.2B)

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, AND THE HUMAN IMMUNODIFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED DEFICIENCY SYNDROME (AIDS).

Executed this _____ day of _____, 20_____

_____	_____
Signature of Witness	Signature of Parent / Guardian