**Denise Childress, MS, LMFT, PLLC.**

**2500 South Broadway, Suite 320, Edmond, OK 73013**

**405-206-8400**

**AUTHORIZATION FOR USE/DISCLOSURE OF CONFIDENTIAL INFORMATION**

By completing this form, you are authorizing the disclosure and/or use of individually identifiable health information, as outlined below, consistent with Oklahoma and Federal law concerning the privacy of such information. All information requested must be provided for this Authorization to be valid.

I understand that treatment services are **NOT** contingent upon or influenced by my decision to permit the information released. I further understand that if the organization or person authorized to receive this information is not required to comply with the Federal privacy regulations, the released information may be re-disclosed and would no longer be protected.

**In order to protect your privacy, only the minimum amount of information will be released to meet your request.**

1. Purpose of Release: .
2. Client Name:
3. Client Date of Birth: (DOB):
4. I authorize ***Denise Childress, MS, LMFT*** to Communicate in: X Writing and/or X Verbally
5. Name of Authorized Person or Agency:
6. Authorized Person/Agency Address:
7. Authorized Person/Agency Phone Number: Fax #:

|  |  |  |  |
| --- | --- | --- | --- |
|  | X Acknowledgement/Verification of Participation in Services  \_\_\_Summary of Treatment Progress  \_\_\_Substance Abuse Records | Treatment Plan  \_\_\_ Diagnostic Information |  |

1. Description of Information to be Released/Disclosed: **Please check only information you would like disclosed:**
2. By signing this release, I and/or my legally authorized representative understand:

* **This Consent will remain *valid for 12 months****.*
* **This Consent may be revoked in writing to *Denise Childress, MS, LMFT* unless action has already been taken based on this release.**
* **The specific types of information being released, the purpose of the release and the period of time for which the information is being released;**
* **I freely and voluntarily give this consent.**

**Client Signature Date (Required)**

**Client’s Parent/Guardian or Legally Authorized Representative Signature Date (Required)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Denise Childress, MS, LMFT Date Approved**

***You have the right to obtain access to or a copy of your health information with the exception as outlined by Oklahoma Law. By law, a reasonable fee may be charged for making copies.***