Morrow Counseling and Psychotherapy PLLC

Authorization for Release of Healthcare Records

Client Name: _____Date of birth: _____

I hereby request and authorize

Alina Morrow LPC
1945 West Concord Circle N
Broken Arrow, OK 74012

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

Provider/Person: _____

Address:_____

City/State/Zip:_____

Phone:_____ Fax:_____

Information to be disclosed includes 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 release prior to receiving the cancellation. A copy of this authorization is as valid as the original.

_____ _____

Signature of Client 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 client or legal representative.