12142 S. Yukon Ave
Glenpool, OK 74033
Phone: 918-935-3636
Fax: 918-296-7934

Consent for the Release of Confidential Information

I, ______________________________ authorize ____**Premier Family Care**____________
(Patient Name – Print) (Medical Facility Releasing Information)

to disclose to **Revolution Health and Wellness Clinic** the following information:

____ Discharge Summary

____ Psychological Evaluation

____ Consultation Reports

____ Progress Notes

____ Education Information

___ All Information

____ Other ________________

____

Exchange of information via: _____ Telephone _____ Correspondence

Information is to be two-way: _____ No _____ Yes

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

Patient Signature ______________________________________ Date ______________

Witness ____ Date ______________