

**Carol Terry Psychological Services, P.C.**  
**1006 24<sup>th</sup> Ave, NW, Suite 100 Norman, OK 73069**  
**Phone: (405) 321-0303 Fax: (405) 801-2846**

**CONSENT TO USE OR DISCLOSE HEALTH INFORMATION**

I authorize CAROL TERRY, PhD. of Carol Terry Psychological Services, P.C.

(Check one or both boxes):  to use and disclose and/or  to obtain the following specific health and medical information to/from:

\_\_\_\_\_  
(Name of person, their title, and organization the information is being released to and/or obtained from)

\_\_\_\_\_  
(Address of Person/Organization the information is to be released to and/or obtained from)

\_\_\_\_\_  
(Fax Number of Person/Organization the information is to be released to and/or obtained from)

\_\_\_\_\_  
(Telephone Number of Person/Organization the information is to be released to and/or obtained from)

for: \_\_\_\_\_  
(Patient's Name)

\_\_\_\_\_  
(Patient's DOB)

**Specific medical information to be released consisting of (Check those that apply):**

- |  |   |
|--|---|
| <input type="checkbox"/> Summary of treatment and treatment recommendations  | <input type="checkbox"/> Psychological Evaluation(s)        |
| <input type="checkbox"/> Other Evaluations (specify): _____  | <input type="checkbox"/> Referral and Insurance Information |
| <input type="checkbox"/> Educational test results, grade reports, school reports of behavior/emotional functioning | <input type="checkbox"/> Individual Education Plan (I.E.P)  |
| <input type="checkbox"/> Alcohol/Substance Abuse Evaluations and Treatment   | <input type="checkbox"/> Other (specify): _____             |

**For the specific purpose(s) of (Check those that apply):**

- Facilitating assessment or treatment       Assisting in educational planning
- Other: \_\_\_\_\_ (list other purposes)

If Carol Terry Psychological Services, P.C. is requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- 1) We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- 2) You may inspect a copy of the protected health information to be used or disclosed;
- 3) You may refuse to sign this Authorization; and
- 4) We must provide you with a copy of the signed authorization.

I understand that the records requested may be protected under 42 C.F. R. Part 2, governing Alcohol Drug Abuse Patient Records and State Confidentiality Laws and regulations and cannot be released without my consent unless otherwise provided for by regulation. State and Federal Law regulations prohibit any further disclosure of such records without my specific written consent or except when otherwise permitted by such regulation.

I also understand that I may revoke this consent in writing at any time unless action has already been taken upon it, and that in any event the consent expires in twelve months from the signing or upon conditions as described above.

**THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE.**

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization. Unless revoked earlier or otherwise indicated, this Authorization will expire 12 months from the date of signing or shall remain in effect for the period reasonably needed to complete the request. You may review Carol Terry Psychological Services, P.C. Notice of Privacy Practices for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent. ***I understand that I have the right to revoke this Consent provided that I do so in writing, except to the extent that Carol Terry Psychological Services, P.C. has already used or disclosed the information in reliance on this Consent.***

  X    
Signature of Parent / Guardian  
Or Adult Client

\_\_\_\_\_  
Print Name of Parent / Guardian  
or Adult Client

\_\_\_\_\_  
Date