

Jack Tracy II, Ph.D. Psychological Services, PLLC

Jack Tracy II, Ph.D., Licensed Psychologist
1006 24th Ave., NW, Suite 100, Norman, OK 73069
Phone: (405) 801-2836 Fax: (405) 801-2846

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION

I authorize Jack Tracy II, Ph.D. of **Jack Tracy II, Ph.D. Psychological Services, PLLC**

(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: _____
(Client's Names) (Client's date of birth)

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

- ☐ Summary of treatment and treatment recommendations ☐ Psychological Evaluation(s)
☐ Other Evaluations (specify) _____
☐ Educational test results, grade reports, school reports of behavior/emotional functioning
☐ Individual Education Plan (I.E.P.) ☐ Alcohol/Substance abuse diagnosis, evaluations and treatment
☐ 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 Jack Tracy II, Ph.D. is requesting this Authorization from you for your own use and disclosure or to allow another health care provider or health plan to disclose information to him:

- 1) He cannot condition the 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) He 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 one hundred and eighty (180) days from the signing or upon conditions as described above, unless a longer period has been specified.

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

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that I have already used or disclosed the information in reliance on this Authorization. Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request. You may review the Notice of Privacy Practices of Jack Tracy II, Ph.D., 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 Jack Tracy II, Ph.D. has already used or disclosed the information in reliance on this Consent.*

A Copy of this Signed Document shall be considered as an Original

Signature of Client or Guardian

Print Name of Client or Guardian

Date