Okapi Counseling and Family Services, PLLC

PATIENT INFORMATION RELEASE

PATIENT NAME (LAST, FIRST, MIDDLE) _____

BIRTHDATE _____ TELEPHONE _____ ALTERNATE PHONE _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PROVIDER

Okapi Counseling and Family Services, PLLC

Cynthia Reese Leon, MA LPC

Type of information to be released (Please be Specific)

_____

_____

REQUESTOR

_____

_____

_____

INFORMATION LIMITATIONS

List any restrictions o information to be released:

_____

I give permission to the PROVIDER to release Medical Record Information to the REQUESTOR concerning the MEDICAL CONDITION/INJURY described above which was diagnosed/treated during the stated TIME PERIOD. The information released will be restricted by any INFORMATION LIMITATIONS outlined above, and may be used only for the purpose described.

I understand that I can cancel this release at any time by notifying the PROVIDER in writing and that my cancellation will take effect when the PROVIDER receives my written notice. I understand that my cancellation will not have any effect on information released before the PROVIDER received my written notice.

Signature of Person Releasing Information: _____

Name of Person Releasing Information (Please Print): _____

Date: _____