



Authorization for Release of Medical Information/Records

Patient Name: _____ **Date of Birth:** _____

I hereby authorize TherapyWorks, Inc. to release photocopies of my medical records and/or health information to the following individual or organization:

I further release TherapyWorks, Inc. from the responsibility of any effect the release of my clinical medical records may have upon myself or others both now and in the future. I personally accept all responsibility for my own distribution and interpretation of medical information contained therein and hold TherapyWorks, Inc. blameless for conclusions or opinions drawn without professional knowledge, assistance or review.

By state law, you must be advised that: The information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus (HIV), also known as Acquired Immune Deficiency Syndrome (AIDS).

Signature

Date

Guarantor Signature
(Authorized person if patient is unable to sign, or under 18 years of age)

Date

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