Restore Life Counseling LLC

Authorization for Release of Healthcare Records

Client Name:_____Date of birth: _____

I hereby request and authorize

Ronny Sommerville LPC
3200 S Elm Pl Ste 101
Broken Arrow, OK 74012

_____To Disclose information to:_____To Receive information from:

Provider/Person:_____

Address:_____

City/State/Zip:_____

Phone:_____Fax:_____

Information to be disclosed includes copies of:

_____Entire Record

_____Progress Notes

_____Other:

_____

_____

_____

_____

This authorization will be effective for one year after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on information release prior to receiving the cancellation. A copy of this authorization is as valid as the original.

_____ _____

Signature of Client Date

Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the client or legal representative.