John Eikel, MA, LPC
Norman Counseling LLC
4330 Adams Rd. ste.
Norman, Ok. 73069

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Authorization for Use/Disclosure of Information: I voluntarily consent to an authorize my health care provider, John Eikel, MA, LPC, to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my or my child's (name of self or child) _____health care information to be released to the following recipient(s):

Name:_____

Address:_____

Purpose: I authorize the release of my health information for facilitation and continuity of counseling services or as required for legal or medical purposes.

Information to be disclosed: I authorize the release of all mental and behavioral health information that is seen as relevant by John Eikel, MA, LPC for the facilitation of individual, couples and /or family counseling, legal or medical purposes.

Term: I understand that this Authorization will remain in effect for one year or until the discontinuation of therapeutic services with stated client(s).

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose indicated health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to John Eikel, MA, LPC. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

_____	_____	_____
Signature	Date	Signature of Witness