Comprehensive Psychological Services
Raymond H. McCaffrey, Ph.D.
510 24th Ave. S.W.
Norman, Oklahoma 73069
Phone 405-329-7923, Fax 405-329-8815

Authorization to Exchange Information

When you complete and sign this form
you authorize me to release information
to or acquire information from another person.

______________________________ ______________________ ____________________
Name of Client | Date of Birth | Social Security Number

I authorize Raymond McCaffrey Jr., Ph.D., to:

RELEASE TO ______ and / or ACQUIRE FROM _____

____
Name

____
Address

____
City / State / Zip

____
Phone

the following information: ____

for the purpose of: ___________________________This consent expires: _____________________

I understand that my records are protected under state federal statutes regarding confidentiality and may not be disclosed without my written consent except in those situations detailed in the Informed Consent that I have previously signed. I also understand that I may revoke this consent at any time except to the extent that action has already been taken based upon it.

Notice
(63 O.S. Supp. 1992, 1-502.2B)

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

Executed this __________________ day of _________________________________,20____________

____ ______________________________
Signature of Witness | Signature of Client

____ ______________________________
Signature of Witness | Signature of Parent or Guardian or Authorized Representative

Note: *Two witnesses are required if client signs with an "X"*