Psychiatry of Tulsa, PC
Hazem Sokkar, M.D.
6108 S. Memorial Drive
Tulsa, OK 74133

Release of Information

Client:_____ **Date:**_____

Date of Birth:___/___/___ **Social Security Number:**_____

_____ I authorize ***Psychiatry of Tulsa/ Hazem Sokkar, M.D.*** to release the following specific information:

_____ I authorize ***Psychiatry of Tulsa/ Hazem Sokkar, M.D.*** to obtain the following specific information:

The type of information to be release:

_____
_____
_____

The purpose of this release is:

_____
_____
_____

This release of Information is valid until _____. This Release of Information is not automatically renewable. It expires automatically at the end of period specified unless revoked in writing.

I understand I have the right to see this information at any time. I understand that I can revoke this consent in writing to both the person giving and the person receiving the information. Any information already released may be used as stated on the consent. By my signature below, I affirm that I have read this release or it has been read to me, and I understand its content.

Client Signature / Date _____

Parent or Guardian's Signature / Date _____
(if client is a minor)

Staff Member's Signature / Date _____