# Connect Counseling Center, LLC

**203 Harnett Ct.**
**Clarksville, TN 37043**

**2640 N. Mount Juliet Rd. Ste. 108**
**Mount Juliet, TN 37122**

**Phone: 931-614-7397 Fax: 931-443-0079**

## Release of Information

Patient Name: _____ DOB: _____

I understand that a mental health provider has an obligation to keep a client's personal information, identifying information, and medical records confidential. I also understand that I can choose to allow a mental health provider to release some of my personal information to certain individuals or agencies.

I, _____, authorize the exchange of information to and/or from Connect Counseling Center, LLC (select Provider)

| Mount Juliet | Clarksville |
|---|---|
| ☐ Joni Batts, LMFT<br>☐ Christa Malcolm, LPCA<br>☐ Rebekah Stone, LMSW<br>☐ Gabriele Aguirre-Iriarte, LPC/MHSP, RPT-S<br>☐ Lauren Kolacinski, LPC/MHSP | ☐ Amanda Bilano, LPC<br>☐ Laura Brittian, LMSW<br>☐ Lynn Burkett, SPE<br>☐ Sierah Campbell, LPC/MHSP<br>☐ Jennifer Castner, LPC/MHSP<br>☐ Carol James, LPC/MHSP<br>☐ Cory Koester, LPC/MHSP<br>☐ Tuesdae Lawrence, MMFT<br>☐ Laura Meadow, LMFT<br>☐ Rachel Tarantino, LCSW<br>☐ Nandy Thompson, LPC<br>☐ Donieka Wood, LPCA<br>☐ Aubrea Dennen, Counseling Intern |
| ☐ **Administrative Staff (both Mount Juliet and Clarksville)** | |

## Information May Be Released/Disclosed To:

Name: _____

Phone #: _____

Fax #: _____

Email: _____

Address: _____

## Type of Information to Release/Disclose:

☐ All Records ☐ Treatment Plans ☐ Diagnosis ☐ Mental Health Summary ☐ Progress Notes

☐ Other:

## The Purpose of Release/Disclosure:

☐ Ongoing Treatment ☐ Coordination of Care ☐ Family/Support System Integration

☐ Legal ☐ Consultation ☐ Evaluation ☐ Health Benefit Utilization ☐ Transfer

☐ Other:

Specific Exceptions: _____

This consent remains in effect for 1 year or until _____ (specify date). I understand that I may revoke this authorization in writing at any time unless action based on it has already taken place.

The designated information about me may be transmitted by fax, other electronic file transfer mechanisms, or discussed by telephone by the authorized individual and/or practice designated above. I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original.

I understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization. The information provided by a client during therapy sessions is legally confidential in the case of licensed psychotherapists, except in certain legal exceptions. In general, these exceptions pertain to matters of danger to self and others, or to prevent the potential abuse or neglect of vulnerable populations. I further understand that the potential exists for disclosure in proceedings or actions by other parties subsequent to the information release authorization and may not be protected under the HIPAA regulations.

This is to certify that I have given consent freely and voluntarily, and the benefits and disadvantages of releasing the information are known to me.

Signature: _____ Date: _____

Print Name: _____

Relationship to Patient: _____

Witness: _____ Date: _____