

# Connect Counseling Center, LLC

203 Harnett Ct.  
Clarksville, TN 37043

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Mount Juliet, TN 37122

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

Phone: 615-438-3615  
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## Authorization to Release Medical Records

Name of Client \_\_\_\_\_ Date of Birth \_\_\_\_\_

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above named client.

### PATIENT INFORMATION IS NEEDED FOR:

- Continuing Medical Care
- Military
- Social Security/Disability
- Insurance
- Personal Use
- Legal Purposes
- School
- Other: \_\_\_\_\_

### INFORMATION TO BE RELEASED OR ACCESSED:

- Mental Health Assessment
- Progress Notes
- Diagnosis
- Treatment Plan
- Other: \_\_\_\_\_

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

TO: \_\_\_\_\_  
(Doctor, Hospital, Attorney, Insurance Company, Self, etc.)

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

\_\_\_\_\_  
Address (Street, City, State and ZIP)

FROM:

Connect Counseling Center, LLC  
203 Harnett Ct.  
Clarksville, TN 37043  
Phone: 931-614-7397 Fax: 931-443-0079

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of mental illness. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. The authorization will expire 1 year from the date of my signature, unless I revoke the authorization prior to that time.

\_\_\_\_\_  
Signature of Client or Legally Authorized Representative

Date: \_\_\_\_\_

\_\_\_\_\_  
Printed Name of Client or Legally Authorized Representative

\_\_\_\_\_  
Relationship to Client