Connect Counseling Center, LLC

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

2031 N. Mount Juliet Rd. Ste. 201
Mount Juliet, TN 37122
Phone: 615-438-3615
Fax: 931-443-0079

Release of Information

Client 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
___ Gabriela Aguirre-Iriarte, LPC/MHSP, RPT-S	___ Diamond Brant, Counseling Intern
___ Joni Batts, LMFT	___ Laura Brittian, LMSW
___ Jennifer Castner, LPC/MHSP	___ Lynn Burkett, SPE
___ Paige Cross, MMFT	___ Sierah Campbell, LPC/MHSP
___ Lauren Kolacinski, LPC/MHSP	___ Jennifer Castner, LPC/MHSP
___ Stephanie Latka, LPC	___ Aubrea Dennen, Counseling Intern
___ Christa Malcolm, LPCA	___ Jenny Hudson, LPC
___ Abby Nesbitt, LPC	___ Carol James, LPC/MHSP-S
___ Rachael Phillips, LPC/MHSP, Ed. D	___ Cory Koester, LPC/MHSP
___ Chloe West, LPC/MHSP	___ Laura Meadow, LMFT
___ Jenny Yelen, MMFT	___ Alana Mrugala, Counseling Intern
___ Rebekah Sharp, Counseling Intern	___ Crystal Nyhus, Counseling Intern
	___ Donieka Wood, LPCA
	___ Rachel Tarantino, LCSW
	___ Nandy Thompson, LPC, RPT
	___ Shawna Cravillion, LPC-MHSP
	___ Amanda Bilano, LPC-MHSP-S

____ 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: _____