Spring Hill Counseling, Inc.

P.O. Box 1912
Spring Hill, TN 37174
(615) 483-7007

Authorization to Release Information

I authorize Spring Hill Counseling, Inc and its staff acting on its behalf to release clinical records, medical history, and treatment summary regarding _____ (client name).

This information should be released only to _____

_____ (name, address of person or agency).

I am authorizing the release of this information for the following reason: _____

_____

This authorization shall remain in effect until _____ (enter expiration date or event that relates to purpose of disclosure).

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the office address: PO Box 1912, Spring Hill, TN 37174. However, my revocation will not be effective to the extent that Spring Hill Counseling, Inc. has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychotherapist generally may not require me to sign an authorization in order to receive psychological services unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient of the information and no longer protected by the HIPAA privacy rule.

_____ _____

Signature of patient/client, parent, or legal representative* Date

*If the authorization is signed by a legal representative of the patient, a description of such representative's authority to act for the patient and necessary documentation must be provided.