AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I, _____, hereby authorize:
Print full name of adult patient or parent/legal guardian of minor child

Denise C. Powell, LCSW, CEAP dba Transitions Counseling, LLC
6918 Shallowford Road Suite 317 Chattanooga, TN 37421
Telephone (423) 855-7977 Fax (423) 855-7976

□ To release protected health information to: _____
Name, Address, and Phone Number of Person/Agency

□ To receive protected information from: _____

□ To exchange protected information with: _____

_____

_____

_____
Phone Number *Fax Number*

I acknowledge that the protected health information to be released concerns the professional services received by: □ myself or □ my minor child or legal charge: _____, and
Print full name of minor child or legal charge

it will be released for the purpose of: _____.
If you are a current patient, "at patient request" is sufficient

*I specifically request that the following information, which may include alcohol or drug related treatment as well as diag*nosis &*/or treatment of HIV or AIS, be sent to Denise C. Powell, LCSW, CEAP:*

□ Interdisciplinary Assessment(s)	□ Medical Treatment	□ Initial Assessment
□ Psychiatric Evaluation	□ List of Medications	□ Verbal Exchange
□ Discharge Summary	□ Psychological Evaluation/Testing Results	□ Other

I understand that I may revoke this consent to release protected health information at any time, by written request. Unless I revoke it, this authorization will remain in effect for one year or until such time as specified herein: _____.

Licensed Clinical Social Workers do not generally make authorizations to release protected information a condition of treatment unless there are clinical indications to do so (i.e.: if important to talk with your psychiatrist or personal condition to coordinate treatment efforts). Your right to revoke authorizations does not apply to if the authorization was obtained as a condition of obtaining insurance and the insurer has a legal right to contest the claim.

I understand that information used or disclosed pursuant to the authorization may be made subject to redisclosure by the recipient of your protected health information and is no longer protected by HIPAA Privacy Rule. I understand all of the aforementioned, and with informed consent of my own free will, authorize this disclosure of protected health information.

_____ _____ _____
Signature of adult patient or parent/legal guardian of minor child *Social Security Number* *Date of Birth*

_____ _____
Witness *Today's Date*