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PERMISSION FOR RELEASE OF INFORMATION

I, _____, hereby authorize Jesse Williams of Trauma and Anxiety Center, LCC located at Suite 314b, 200 East Broadway Avenue, Maryville, TN 37804 (phone: 865-518-9922) to:

□ disclose information to □ receive information from □ exchange information with

Name(s): _____ Phone #: _____

Name or Agency Name: _____

Address:_____
(street) (city) (state) (zip)

Regarding: _____ Client Phone:_____
(Client Name – please print)

Client Address: _____
(street) (city) (state) (zip)

DOB: _____ SS#:_____

The information to be disclosed is:
□ Presence/Participation in Treatment Information
□ Summary of Treatment
□ Diagnosis
□ Assessment
□ Treatment Plan/Summary
□ Treatment Updates
□ Educational Information
□ Continuing Care Plan
□ Discharge/Transfer Summary
□ All psychotherapy notes* *(Cannot be combined with other disclosures)*
□ Other (specify)_____

The purpose of this disclosure is to further mental health treatment through increasing connection between practitioners and/or other related parties.

If the purpose is other than as specified above, please specify:

_____

_____

_____

This consent is effective on _____ and expires on _____.

I understand that I may revoke this consent at any time by giving written notice to the person or organization making this disclosure.

Client Signature: _____

Therapist Name: _____

NOTICE: *This information has been disclosed from confidential records. Any further disclosure without the specific written consent of the person to whom it pertains exceeds the limits of this release. (However, there are legal and ethical requirements that counselors take responsible action in those situations as prescribed by law 1) where there is danger of imminent harm to self or others, and 2) in the case of apparent child abuse.)*