805 S Church Street
Suite 20
Murfreesboro, TN 37130

TUCKER-HUGGINS & ASSOCIATES

1114 N Main Street
Suite B
Shelbyville, TN 37160

Authorization to Disclose/Receive Protected Health Information

Client Name: ______________________________ DOB ______________

Address: ______________________________ SSN ______________

______________________________ Phone: ______________

I hereby authorize

□ **Laura L. Tucker-Huggins, LPC/MHSP** □ **Amanda Lenahan** □ **Bridgette Davenport**

to release/exchange/receive verbal and written communication and information with the following identified individual:

ATTORNEY/COUNSEL NAME:______________________PHONE/FAX:______________

The following information:

□ Psychiatric/Psychological/Social History	YES ______	NO ______
□ Psychological, psychiatric, or neurological evaluations/testing/results	YES ______	NO ______
□ Physical Examination Results	YES ______	NO ______
□ Medical History	YES ______	NO ______
□ Current Medical Status	YES ______	NO ______
□ Medications Currently Prescribed	YES ______	NO ______
□ Substance Abuse/Dual Diagnosis	YES ______	NO ______
□ Periodic reports of current treatment progress, barriers to treatment, or prior treatment	YES ______	NO ______
□ OTHER: ______________________	YES ______	NO ______

The purpose of the disclosure of the above information is:

____

I understand that this release of information is subject to revocation by me, in writing, at any time and that this release is not valid beyond one year (________________). I also understand that the person(s) or agency receiving this information is prohibited from making any further disclosure of such information except with my specific consent.

______________________________ ______________________________
Signature Date

If not signed by client, state relationship to the client: ______________________________

______________________________ ______________________________
Witness Signature Date

This information has been disclosed to you from records that are confidential. Federal law protects this confidentiality. Federal regulation (42 CFR, Part 2) prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

Client Name: **Medical Record:**