Christina R. Perkins, LCSW
4877 Chambliss Ave
Knoxville, TN 37919
P: (865) 924-2558 F: 866-768-6708

Authorization for Exchange of Information

I _____ authorize the exchange of information between
☐ client ☐ parent of client ☐ legal guardian of client

Christina R. Perkins, LCSW
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Knoxville, TN 37919
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and

Name: _____
Address: _____
_____
Phone: _____
Fax: _____

concerning_____ ___-___-____ ___/___/____
(client's name) (SS#) (date of birth)

The agencies and/or individuals named above may exchange (please initial all that apply):

____ Any and all Mental Health information _____Medical (which may include drug/alcohol and mental health information)

___Progress Notes _____ Attendance records only Other information, please specify: _____

This disclosure may be: ____ Verbal and/or _____Copies of Records

for the purpose of _____.

This consent expires on _____ unless otherwise revoked in writing. If no date is indicated, this consent is valid through 10 years after date of last therapy session for adult clients or on the 18th birthday of client is a child or adolescent.

- I understand that I have no obligation whatsoever to disclose the requested information and that I may revoke this consent at any time by informing the therapist in writing.
- If I refuse to consent to this release of information, I understand that the following are the possible consequences:
  _____

If the information to be used or disclosed contains any of the types of records or information italicized below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be used or disclosed if I place my initials in the applicable space next to the type of information:

____***Alcohol/Drug*** diagnosis, treatment, or referral information (Federal regulation (in 42 CFR Part 2) requires a description of how much and what kind of information is to be disclosed).

Please check either ***ALL*** or ***Limited*** to indicate how much Alcohol/Drug information is to be disclosed:
☐ All A&D information or ☐ Limited information (if Limited Alcohol/Drug, specify by checking the applicable choices of information below).
Indicate the information that is to be disclosed by checking the choices below:
☐ Diagnosis ☐ Progress Report(s) ☐ Assessments ☐ Treatment Plan ☐ Discharge Summary ☐ Evaluations
☐ Other (specify): _____
_____

In consideration of this consent, I hereby release the above parties from any legal liability resulting from the release of this information.

Client/Guardian Signature:_____ Date:____/____/____

Relationship to Client/Patient: _____

Therapist Signature:_____ Date:____/____/___

*NOTICE TO RECEIVING PERSON/AGENCY: *You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure.*