Association of Behavioral Counselors PLLC

367B N. Parkway, Suite 1
Jackson, TN 38305
(731) 668-2277
Fax: (731) 660-0510

Sandy Sarten, Office Manager

David Pickering, Ph.D.
Mike Cravens, L.M.F.T.
Deryl Hilliard, Ed.D.
John H. Redden, LPC/MHSP
Sherry Thompson, LPC/M.Ed.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient: _____

SSN: _____

DOB: _____

I hereby authorize _____
Name

367B North Parkway Jackson, TN 38305 Phone: 731-668-2277 Fax: 731-660-0510

to ☐ release to, ☐ receive from, or ☐ exchange with _____
Name

_____
Address City, State and Zip

_____
Phone Fax

protected health information concerning professional services received by myself or my minor child or legal charge named above as follows: _____

- ☐ Psychiatric evaluation reports
- ☐ Psychological test reports
- ☐ Intake assessment
- ☐ Attendance/participation
- ☐ Social history to include presenting problems, family, education, employment, alcohol/drug, legal/arrests, medical, medications, allergies/drug reactions, emotional/psychological and living skills.
- ☐ Treatment plan and progress in treatment
- ☐ HIV/Aids Information
- ☐ Other (Specify) _____

For the purpose of :

- ☐ Developing a diagnosis, treatment, and/or rehabilitation
- ☐ Coordinating medical, psychological, and social rehabilitative processes
- ☐ Other (Specify) _____

I understand that this authorization shall remain in effect for a period of one year or until revoked in writing.

_____ _____
Signature of Patient or Parent of Minor or Legal Charge Date

If legal charge, provide description of such representative authority. _____