



Authorization to Release Protected Health Information

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Client Name: _____ Birthdate: _____

Address: _____

City: _____ State: _____ Zip: _____

SSN: _____ Phone: _____

I authorize New Beginnings Counseling Center to disclose information from my mental health record to:

Provider's Name: _____

Facility Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Information to be received/released (check all that apply):

- Initial notification of services being received at NBCC
- Psychological and/or educational evaluation
- Diagnosis
- Progress notes
- Treatment information and updates
- Any applicable mental health information
- Other (specify): _____

Purpose of disclosure:

- Coordinate care with other providers
- Participate in counseling sessions as part of my treatment
- Referral for additional treatment/services
- Other (specify): _____

Your signature below indicates that you understand the following information:

- This authorization shall remain in effect for one year after date of consent unless otherwise specified.
- You may request a copy of this form after you sign it.
- You may revoke this authorization at any time by notifying New Beginnings Counseling Center in writing. It will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
- Federal law/42 CFR part 2 prohibits unauthorized disclosure of information regarding the treatment of substance use disorders.

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Signature of Client (or Parent/Guardian if under 18)

Date

Printed Name of Client (or Parent/Guardian if under 18)

Relationship to Client
(If applicable)