ASPIRE GROWTH COUNSELING
141 N. Martinwood Rd., Suite 103-20
Knoxville, TN 37923-5137
865-236-1442

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

This authorizes Sondra Wilkinson, LPC-MHSP at Aspire Growth Counseling to disclose information concerning

me, _____

to and from _____

The purpose of this disclosure is related to my therapeutic work including: (initial all that apply)

_____ medical records
_____ diagnostic impressions
_____ treatment process & response to treatment
_____ psychosocial history
_____ progress
_____ telephone consultation
_____ other (specify) _____
_____

I authorize the disclosure of my protected health information (*). I understand that this authorization is voluntary. I understand that if the person(s) that I authorize to send/receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organizations may not be protected by those laws. This release shall remain in effect for one (1) year after the signing date of this release or until canceled by me in writing at any time or on the following date_____.

Signature _____ Date _____

Witness _____

*Protected health information (PHI) is health information that is created or received by a health care clearing house which relates to 1.) the past, present, or future physical or mental health of an individual; 2.) the provision of health care to an individual; or 3.) the past, present, or future payment for the provision of health care to an individual. To be protected, the information must be such that it identifies the individual or provides a reasonable basis to believe that the information can identify the individual. 45 C.F.R