Tennessee Art Therapy and Counseling, LLC
▪ phone: 423-203-8600 ▪ fax: 888-248-7189 ▪ elizabeth@tennesseearttherapy.com ▪

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

Name_____ **DOB**_____

THE PERSON LISTED ABOVE IS GIVING CONSENT FOR THE BELOW INFORMATION TO BE RELEASED FOR THE PURPOSE TO ASSIST IN MENTAL HEALTH TREATMENT.

To: Tennessee Art Therapy and Counseling **From:** _____**(Name)**

_____**(Phone)**

_____**VERBAL/WRITTEN INFORMATION RELATED TO CLIENT'S EMOTIONAL/BEHAVIORAL PROBLEMS AND TREATMENT**

_____ **PSYCHOSOCIAL ASSESSMENT / ADMISSION SUMMARY**

_____ **TREATMENT PLAN**

_____ **COUNSELING/PROGRESS NOTES FROM PAST 6 MONTHS**

_____ **MEDICATION MGT NOTES FROM PAST 6 MONTHS**

_____ **MEDICATION SHEETS/MAR (FROM INPATIENT/RESIDENTIAL FACILITY)**

_____**DISCHARGE SUMMARY**

_____**PSYCHIATRIC / PSYCHOLOGICAL EVALUATION**

_____**COURT/PROBATION RECORDS FROM PAST 6 MONTHS**

_____**OTHER** _____

From: Tennessee Art Therapy and Counseling **To: Above Named Individual**

_____ **ASSESSMENT/ TREATMENT PLAN**

_____**VERBAL/WRITTEN INFORMATION RELATED TO CLIENT'S EMOTIONAL/ BEHAVIORAL PROBLEMS AND TREATMENT**

_____**OTHER:**_____

*** I UNDERSTAND I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME. I UNDERSTAND IF I REVOKE THIS AUTHORIZATION, I MUST DO SO IN WRITING AND PRESENT MY WRITTEN REVOCATION TO TENNESSEE ART THERAPY AND COUNSELING. I UNDERSTAND THE REVOCATION WILL NOT APPLY TO INFORMATION THAT HAS ALREADY BEEN RELEASED IN RESPONSE TO THIS AUTHORIZATION.**

*** I UNDERSTAND THAT AUTHORIZING THIS DISCLOSURE IS VOLUNTARY. I MAY REFUSE TO SIGN THIS AUTHORIZATION. I UNDERSTAND ANY DISCLOSURE OF INFORMATION CARRIES WITH IT THE POTENTIAL FOR AN UNAUTHORIZED REDISCLOSURE AND THE INFORMATION MAY NOT BE PROTECTED BY FEDERAL CONFIDENTIALITY RULES. IF I HAVE ANY QUESTIONS ABOUT DISCLOSURE OF MY INFORMATION, I CAN CONTACT TENNESSEE ART THERAPY AND COUNSELING.**

CLIENT _____ **DATE** _____

Revised 4/27/24