Brian Hooper, M.Div., Psy.D., LCPT
4525 Harding Road, Suite 207
Nashville, TN 37205

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH RECORD

(Also known as Protected Health Information)

Client Name
_____DateBirth_____
Address (Mailing)_____
_____
_____

Phone _____

I authorize Brian Hooper, Licensed Clinical Pastoral Therapist to use or disclose information from my mental health record, which may include information about diagnosis and treatment and substance abuse issues to:

Name: _____ Phone_____

Address:_____
_____
_____ FAX _____

Dates of Treatment:
_____
Information to be released (Please describe)
_____
_____
Purpose of Disclosure
_____
_____
_____

1. I understand that, unless withdrawn, this authorization will expire 180 days from the date of signature. A photocopy of this form will be considered as valid as the original.

2. I understand that I may revoke this authorization at any time by notifying Dr. Hooper at the address indicated above, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information and mental health information.

4. I understand that I can request a copy of this form after I sign it.

5. I understand that if Dr. Hooper provides an original summary of notes, and not my entire record, he will be compensated according to the agreed upon rate for a one hour therapy session, charging by the quarter of each hour necessary to summarize notes.

By signing below, I acknowledge that I have read and understand this Authorization.

_____ Date _____

OR

Signature of Patient's Parent/Legal Guardian/Authorized Person

_____Date_____

Relationship to Patient_____