

Maggie Hope, LPC, MHSP  
2323 21<sup>st</sup> Ave. S.  
Nashville, TN 37212  
615-417-9707

Authorization For Release of Information

Date: \_\_\_\_\_

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

I hereby authorize the release of my protected health information

FROM Maggie Hope, LPC, MHSP  
2323 21<sup>st</sup> Ave. S.  
Suite 301  
Nashville, TN 37212  
Phone 615-417-9707

TO \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Phone \_\_\_\_\_  
Fax \_\_\_\_\_

I understand that the information will be used in the development of a diagnosis and treatment plan and/or to coordinate medical, psychological, and social rehabilitation services.

I understand that this information will not be disclosed to any other agency or individual without my written authorization, except as allowed by law. I also understand that any agency or individual who receives my protected health information is prohibited from redisclosing the information.

This authorization may be revoked at any time by my written statement. This authorization for release of information is given freely, voluntarily and without coercion.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date