

Association of

Behavioral

367B N. Parkway, Suite 1
Jackson, TN 38305
(731) 668-2277
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Counselors PLLC

David Pickering, Ph.D.
Mike Cravens, L.M.F.T.
Deryl Hilliard, Ed.D.
Sandy Sarten, L.C.S.W.
Bruce R. Lockwood, Ph.D.
Frances M. Lockwood, Ph.D.

NAME OF PATIENT: _____
FIRST MIDDLE LAST

SOCIAL SECURITY #: _____ - _____ - _____

DATE OF BIRTH: ____/____/____

I hear by authorize _____
Name
367B North Parkway. Jackson, TN 38305 Phone: 731-668-2277 Fax: 731-660-0510

to release to, receive from, or exchange with _____
Name

ADDRESS _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: (____)____-____ FAX: (____)____-____

Protected health information concerning professional services received by myself or my minor child or legal charge named above as follows: _____

- Psychiatric evaluation reports
- Psychologist test reports
- Intake assessment
- Attendance/participation
- HIV/Aids Information
- Social history to include presenting problems, family, education, employment, alcohol/drug legal/arrests, medical, medications, allergies/drug reaction, emotional/psychological and living skills..
- Treatment plan and progress in treatment
- Other (Specify) _____

For the purpose of:
 Developing a diagnosis, treatment, and/or rehabilitation
 Coordination medical, psychological and social rehabilitative processes
 Other (Specify) _____

I understand that this authorization shall remain in effect for a period of one year or until revoked in writing.

Signature of Patient or Parent of Minor or Legal Charge

Date

