Kirsten Cropp
1410 17th Avenue South
Nashville, Tennessee 37212
Phone: 615-202-6508

Authorization for Release of Information

Name: _____ Date of Birth:_____ SSN#:_____

I hereby authorize the release of my protected health information.

From Kirsten Cropp, LCSW

To: _____

Phone: _____ Email: _____

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

_____

Relationship to the Client

_____

Witness