Brandon Teeftaller APN
P.O. Box 42029
Nashville, TN 37204
Ph 615-301-8681
Fax 615-301-1603

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize to Athena Consulting and Psychological Services, LLC release healthcare information of the patient named above to:

Name: Brandon Teeftaller APN

Address: P.O.Box 42029

City: Nashville State: TN Zip Code: 37204

This request and authorization applies to:

□ Healthcare information relating to the following treatment, condition, or dates: _____

_____

□ All healthcare information

□ Other _____

Yes No I authorize the release of any mental health treatment to the person(s) listed above

Yes No I authorize the release of any records regarding drug or alcohol.

Patient Signature: _____ Date Signed: _____

Personal Representative & Relationship To Patient: _____

THIS AUTHORIZATION EXPIRES SIX MONTHS AFTER IT IS SIGNED.