

Authorization for  
Release of Information  
Sandy O'Donnell, LPC/MHSP  
2300 21<sup>st</sup>. Ave., South; Ste. 303  
Nashville, TN 37212

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby authorize the release of information with regard to my mental health Treatment by Sandy O'Donnell, LPC/MHSP to the following individual(s):

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

I understand that this information will be used for the purpose of developing a diagnosis and treatment plan, and to coordinate medical, psychological, and social rehabilitation. I understand that there are limits to confidentiality and that if I am deemed a threat to Myself or others, Sate and Federal law requires reporting of same. Additionally, if there is any abuse of a minor or elder, the law requires that this be reported as well.

Client: \_\_\_\_\_

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

Parent (if appropriate): \_\_\_\_\_

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