1810 Ward Drive
Suite 103
Murfreesboro, TN 37129
615-809-2090 (fax)

TUCKER-HUGGINS & DRIGGS
Professional Counseling Services

Laura L. Tucker-Huggins, LPC/MHSP
931-212-7227
Deborah A. Driggs, LPC/MHSP
931-581-0524

Authorization to Disclose Protected Health Information to Your Primary Care Physician

Communication between your behavioral health provider and your primary care physician (PCP) is important to make sure all care is complete, comprehensive and well-coordinated. This form allows your behavioral health provider at TUCKER-HUGGINS & DRIGGS to share valuable information with your PCP. No information will be released without your signed authorization

Section 1: The Client

First Name	*Middle Initial*	*Last Name*	
Address		*Date of Birth*	*Phone*

I hereby authorize the disclosure of protected health information about the individual named above and declare that I am:
_____ the individual named above **OR** _____a personal representative because the patient is a minor, incapacitated or deceased.

Section 2: Person/Agency Disclosing Information

Provider's Name	*Address*	*Provider's Contact Phone*
□ Laura L. Tucker-Huggins, LPC/MHSP □ Deborah A. Driggs, LPC/MHSP	1810 Ward Drive, Suite 103, Murfreesboro, TN 37129 Fax Number: 615-809-2090	□ 931-212-7227 □ 931 581-0524

Section 3: Recipient of Information

Name of PCP	*Phone*
Street Address, City, State, and Zip Code	

Section 4: Information That Will Be Disclosed

Any applicable behavioral health and/or substance abuse information, including diagnosis, treatment plan, and prognosis.

Section 5: The Purpose of the Disclosure

To release behavioral health evaluations and/or treatment information to the PCP to ensure quality and coordination of care.

My signature indicates my willingness to have information provided to my PCP.

Signature: _____ Print Name: _____

Date: _____ Signed by: __client __guardian __personal representative

Section 6: Right to Refuse Disclosure

I am invoking my right for my information to remain completely confidential and thus refusing release of my records to my PCP.

Print Name: _____ Date: _____

Signature: _____ Signed by: __client __guardian __personal representative