**AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION**

# Instructions: Fill in the appropriate information in each applicable section. Sign, date, and return the form. Incomplete forms will be returned to you unprocessed. A separate authorization must be completed for each request.

Patient Full Name: Date of Birth: \_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I hereby authorize:**  **release information to:** **exchange information**

|  |  |  |
| --- | --- | --- |
| **Name:**  East Tennessee Behavioral Health | **Name:** |  |
| **Address: 1444 Old Weisgarber Rd** | **Address:** |  |
| **Knoxville, TN 37909** |  |  |
| **Phone: 865-722-7780 fax: 865-219-1367** | **Phone: Fax:** |  |

By signing below, I hereby authorize “Facility” or agent, to disclose information contained in the medical and financial record of the patient identified above, which includes information that may be stored in a paper and/or other electronic format. However, such notes may contain information on general medical care; alcohol and drug abuse treatment; psychological and social work counseling; human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS), or AIDS related complex. Including communicable diseases or infections, sexually transmitted diseases, venereal diseases, tuberculosis and hepatitis; demographic information; and treatment received at other health care facilities.

Disclosure shall be limited to the following specific information contained in my records and/or obtained during the course of my diagnosis and treatment.

**The following information is requested: (patient\* or legal guardian √ items to be released).**

|  |  |  |
| --- | --- | --- |
| \_\_Psychiatric Evaluation | \_\_Laboratory Reports | \_\_\_Financial Account information |
| \_\_History & Physical | \_\_Immunization Records | \_\_\_Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_Practitioner Orders | \_\_Medication Records | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_Practitioner Progress Notes | \_\_Treatment/Individualized Service Plan | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_Discharge Summary | \_\_Discharge Instructions | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |

**The Purpose or Need for Disclosure is:**

|  |  |  |
| --- | --- | --- |
| \_\_To Transfer Client Care | \_\_To Aid in Treatment | \_\_Application for Provider Coverage |
| \_\_For Follow Up Care | \_\_For Discharge Planning | \_\_Psychological Report |
| \_\_To Inform Family | \_\_To Update Medical Records | \_\_To Aid in financial account activity |
| \_\_Referral Source | \_\_Employer | \_\_Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_Legal/Court System |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

I understand that the information in my health record may include information relating to sexually transmitted disease, immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. ***State and federal law protect the following information. If this information applies to you, please (*√) *indicate if you would like this information released/obtained*** (include dates where appropriate):

Alcohol, Drug, or Substance Abuse Records \_\_ Yes \_\_ No Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HIV Testing and Results \_\_ Yes \_\_ No Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental Health Records Dates: \_\_ Yes \_\_ No Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Disclosure Format (Paper/US Mail or Fax is default if not marked.): Specify** ¨E-mail” or other Electronic format¨: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization is valid only if received within 60 days of being signed. This authorization will expire at the time of disclosure of requested information or on -------- (date cannot be more than 180 days after date signed below).

* + I may revoke this authorization at any time. Revocations to this authorization must be presented in writing. Revocation will not apply to information disclosed prior to receiving a written revocation.
  + I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy laws and regulations.
  + I understand that East Tennessee Behavioral Health will not condition my treatment, payment, enrollment or eligibility for benefits on whether I provide this authorization.

By signing below I acknowledge that I am aware of the confidential and/or privileged nature of the information being disclosed, and understand the benefits and/or disadvantage of disclosing such information. I hereby release above Facility, its affiliates and its agent and representatives, (including collection agencies) from all legal liabilities that may result from the release of this information according to this request. I also expressly consent and authorize to be contacted by the phone number provided (cellular or residential) by any type of voice method and by auto-dialer technology for any permissible purpose.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Authorized Representative Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Relationship to Patient (if applicable)*.*