Standard Authorization for the Release of Patient Information

To whom it may concern:

All requests for Health Information from Cumberland Heights must be either:

- Notarized
  OR
- Presented with a **copy of Photo ID** of the patient

The PATIENT must initial next to EACH ITEM and sign and date the request

The completed form can be faxed to Cumberland Heights Medical Records at 615-432-3291 or mailed to:

Cumberland Heights
8283 River Road Pike
Nashville, TN 37209
ATTN: Medical Records

Thank You
Cumberland Heights
Medical Records

cumberland heights

Standard Authorization for the Release of Patient Information

Release Information Regarding:

Patient Name: ________________________________

Date of Birth: ________________________________

Date of Admission: ___________________________

Client ID #: ___________________________

Relationship to Patient ________________________

☐ **Minor under 18 years old**

Release Information To/From:

Name:____

Address:____

____

Phone #: ____

Alt. Phone#:____

Fax #______________________ **secure/private fax #** ☐**Yes** ☐**No**

☐ I have been informed of the potential risks of transmitting protected health information (PHI) via electronic mail. I hereby give permission to allow my PHI be sent as authorized by this Release of Patient Information via electronic mail. **Email address**:____________________________________

PURPOSE: The purpose of this disclosure of information is to improve assessment and treatment planning. The sharing of information is relevant to treatment and when appropriate, to coordinate treatment services and continuing care planning. If for other purpose, specify: ____________________

REVOCATION: I understand I have a right to revoke this authorization in writing at any time by sending written notification to the Medical Records Supervisor, Program Clinical Manager or the Nursing Supervisor on Duty at PO Box 90727, 8283 River Road, Nashville, TN 37209. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Information which can be disclosed: (*PLEASE INITIAL EACH ITEM THAT IS TO BE RELEASED*)

I understand and acknowledge that this authorization extends to all or any part of the records selected below which may include documentation of treatment for mental health disorders, substance use disorders and/or HIV/AIDs test results or diagnosis.

INITIAL	
________	Demographic Information
________	Presence in Treatment
________	Dates of Admission and Discharge
________	Initial Assessment & Recommendations
	Emergency Contact

INITIAL	
________	Diagnosis
________	Medical History (Physical Exam, Health History)
________	Nursing Information (Assessment, Notes, Vital Signs)
________	Medication Management Information
________	Psychiatric Evaluation & Notes
________	Psychological Evaluation & Notes
________	Drug Screens/Lab Results
	Other:

INITIAL	
________	Biopsychosocial
________	Treatment Plan
________	Progress in Treatment
________	Progress Notes
________	Discharge/Transfer Summary
________	Continuing Care Plan
________	Aftercare Participation
	Recovery Support Services Progress

INITIAL	
________	Family Group Therapy
________	Family Individual Therapy
	Recovery Family Support Services

INITIAL	
	Academic Information

INITIAL	
	Financial/Insurance

EXPIRATION: Unless sooner revoked, this consent expires 18 months from the date of my signature, unless otherwise indicated: ________________

CONDITIONS: I further understand that Cumberland Heights Foundation will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:
____

FORM OF DISCLOSURE: Unless I have specifically requested in writing that the disclosure be made in a certain format, Cumberland Heights reserves the right to disclose information as permitted by this authorization in any manner that Cumberland Heights deem to be appropriate and consistent with applicable law, including, but not limited to, verbal, paper, and electronic (encrypted email/digital) formats.

RE-DISCLOSURE: Federal Law prohibits the person or organization to whom disclosure is made from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2.

Upon my request, I understand that I will be given a copy of this authorization for my records.

NOTE: THIS DOCUMENT MUST BE NOTARIZED OR *PRESENTED WITH A COPY OF* A VALID PHOTO ID *WITH SIGNATURE:*

Signature of Patient ____ Date: ___________________________

Signature of Parent or Guardian _____________________________________ Date: ___________________________