



AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Printed Name of Consumer _____ Case # _____
Previous Names, If Applicable _____

Date of Birth _____ Social Security # _____

RELEASE TO/FROM: (Authorize Release and Request Information between both listed below)

Mental Health Cooperative Name _____
275 Cumberland Bend Address _____
Nashville, TN 37228 City, State, Zip _____
Tel: 615-726-3340 Phone _____
Fax: 855-311-1617 Fax _____

Treatment Dates Requested: Most Recent Encounter Other: From _____ to _____ Last 2 years
MM-DD-YY MM-DD-YY

INFORMATION TO BE RELEASED			PURPOSE OF DISCLOSURE	
Information requested in PCP letter	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Continued Care	
Admission History, H&P, Discharge Summary, Laboratory Reports	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Self	
Psychological / Psychiatric Evaluations / Neurological Workup	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Specialist	
Treatment Plans and Progress Notes including current medications	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> PCP Communication and Care Coordination	
School Records	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Permission to Provide Services at School	
Verbal Communication	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Other (specify): _____	
Other (specify): _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No		

Initial if you DO NOT want the following portions of your medical records released:

_____ Psychiatric & Mental Health Records
_____ HIV/AIDS Records
_____ Substance Abuse (Drug & Alcohol) Records

- I am between the ages of 16 years and 17 years old and DO NOT want communication sent to my parent/legal guardian
- DO NOT communicate with my PCP

I understand that this information will not be disclosed to any other agency or individual without my written authorization, except as allowed by law. I also understand that my protected health information, which is disclosed with this release, may be subject to redisclosure by the recipient and no longer protected by law. MHC is not responsible for any alterations made on its medical record copies, which have been released to any party. I understand that I have a right to a copy of this authorization after I sign it. I understand that MHC will not condition treatment on the completion of the authorization. A faxed authorization is as valid as the original. The authorization automatically expires 12 months from the date it was signed or when services are terminated. I understand I can revoke this authorization at any time by sending written notice to MHC's Privacy Official at 275 Cumberland Bend, Nashville, TN 37228, except for disclosures already made based upon my original permission.

This authorization is given freely, voluntarily and without coercion.

Signature of Consumer or Representative _____ Date _____ Consumer Other _____ Specify Relationship _____

Witness _____ Date _____

Notice to person or organization receiving the accompanying disclosure: This information has been disclosed to you from records protected by federal and state confidentiality rules and laws (42 CFR Part 2 and TCA 33-3-104, and 45 CFR, Parts 160 and 164).

Parental Signature Required for Consumers 15 Years and Younger