

STANDARD AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

To Whom It May Concern:

To request patient health information from Cumberland Heights, please complete the attached form and do ONE of the following:

- Have the form notarized by a notary public
OR
- Include a copy of the patient's photo ID with the completed form

Please note: The patient must initial next to each item that is to be released, and sign and date at the bottom of the form.

The completed form can be faxed to Cumberland Heights Medical Records at (615) 432-3291, emailed to medicalrecords@cumberlandheights.org, or mailed to:

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

Thank you,
Cumberland Heights Medical Records



Standard Authorization for the Release of Patient Information

Release Information Regarding:

Patient Name: _____

Date of Birth: _____

Date of Admission: _____

Client ID #: _____

Release Information To/From:

Name: _____

Address: _____

Phone #: _____

Fax #: _____ secure/private Yes No

Relationship to Patient _____

Email: _____

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

INITIAL	
_____	Demographic Information
_____	Presence in Treatment
_____	Dates of Admission and Discharge
_____	Prescreen Assessment & Recommendations
_____	Initial Assessment & Recommendations **LEGACY
_____	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
_____	Psychotherapy Notes
_____	Drug Screens/Lab Results
_____	Other:

INITIAL	
_____	Biopsychosocial **LEGACY
_____	BPSS Assessment
_____	Treatment Plan
_____	Progress in Treatment
_____	Progress Notes
_____	Discharge/Transfer Summary
_____	Continuing Care Plan/Medical Discharge Note
_____	Aftercare Participation
_____	Recovery Support Services Progress
INITIAL	
_____	Group Family Therapy
_____	Individual Family Therapy
_____	Family Education Program
_____	Family Recovery Support Services
INITIAL	
_____	Academic Information
_____	Financial/Insurance

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: _____

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

REVOCAION: 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.

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.

EMAIL: 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 to be sent as authorized by this Release of Patient Information via electronic mail.

EXPIRATION: Unless sooner revoked, this consent expires 24 months from the date of my signature, unless otherwise indicated: _____

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: _____