Park Center
Recovery From Mental Illness

AUTHORIZATION FOR RELEASE AND EXCHANGE OF PROTECTED HEALTH INFORMATION

Full Name: _____ SSN: _____ DOB: _____

*I authorize **Park Center** to:*

X *Exchange Information with:* ☐ *Release Information to:* ☐ *Obtain Information from:*

Provider/Organization/Individual Name: _____

Address: _____

Phone: _____ Fax: _____

Purpose of Disclosure: ☐ Continuity of Care **X** Referral for Services ☐ Other _____

Treatment Dates to Release: **X** Any and All Records ☐ Date Range From: _____to_____

The following information may be disclosed:

- ☐ Entire client record
- **X** Alcohol/Drug Treatment Records
- **X** Crisis Plan/Service Plan
- **X** Current Medications
- ☐ Discharge Summary
- ☐ Educational Records
- **X** History and Physical Exam
- **X** HIV/AIDS test results and treatment
- **X** Medication Records
- **X** Mental/Behavioral Health Records
- **X** Progress Notes
- **X** Psychiatric Assessment
- ☐ Psychotherapy Notes
- ☐ Attendance/Participation
- **X** Other: DSM V Diagnoses

I understand the following:

This authorization will expire 12 months from the date signed. This authorization may be revoked at any time by sending a written notice to Park Center, 801 12th Avenue South, Nashville, TN 37203. I understand that the revocation will not apply to information that has already been released based on this authorization. Information we disclose may no longer be protected by federal law and could be re-disclosed by the receiving party. I may refuse to sign this authorization and that the facility will not condition treatment or services on whether or not I sign this authorization.

_____ _____

Signature of Member Date

_____ _____ _____

Witness Signature Date Date release expires

_____ _____

Conservator Signature *(where applicable)* Date

Notice to person/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)