



AUTHORIZATION FOR RELEASE AND EXCHANGE OF PROTECTED HEALTH INFORMATION

Full Name: _____ SSN: _____ DOB: _____

This release authorizes Park Center to:

- Release Information
- Obtain Information

Purpose of Disclosure: Continuity of Care Referral for Services Other _____

The following information may be disclosed:

- | | |
|---|--|
| <input checked="" type="checkbox"/> Entire client record | <input checked="" type="checkbox"/> Medication Records |
| <input checked="" type="checkbox"/> Alcohol/Drug Treatment Records | <input checked="" type="checkbox"/> Mental/Behavioral Health Records |
| <input checked="" type="checkbox"/> Crisis Plan/Service Plan | <input checked="" type="checkbox"/> Progress Notes |
| <input checked="" type="checkbox"/> Current Medications | <input checked="" type="checkbox"/> Psychiatric Assessment |
| <input checked="" type="checkbox"/> Discharge Summary | <input checked="" type="checkbox"/> <u>DSM V Diagnoses</u> |
| <input checked="" type="checkbox"/> Educational Records | <input checked="" type="checkbox"/> Attendance/Participation |
| <input checked="" type="checkbox"/> History and Physical Exam | <input checked="" type="checkbox"/> Other: Program History |
| <input checked="" type="checkbox"/> HIV/AIDS test results and treatment | |

Treatment Dates to Release: Any and All Records Past 6 mo. Past 2 years

Please list the individual's current treatment provider from whom Park Center has authority to release information to and/or obtain information from: _____
(name of provider/treatment organization)

Address: _____

Phone: _____ **Fax:** _____

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, 186 N. 1st St., Nashville, TN 37213. 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)