VOLUNTEER BEHAVIORAL HEALTH

O The Guidance Center
2126 Thompson Lane
Murfreesboro, TN 37129

O The Guidance Center
118 N. Church Street
Murfreesboro, TN 37133

O The Guidance Center
1915 Columbia Avenue
Franklin, TN 37064

O The Guidance Center
131 Mayfield Drive
Smyrna, TN 37167

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

_____ _____ _____-__-_____

Client's Full Name | Date of Birth | Social Security Number

FROM/TO:_____

(Name and Address of Person or Agency sending the information)

TO/FROM:_____

(Name and Address of Receiving Person or Organization)

TYPE OF INFORMATION TO BE RELEASED PERTAINS TO: Mental Health Information, Residential Information, Care Coordination Information, Substance Use Information and/or General Medical Information. I understand that my medical records may contain information regarding the diagnosis or treatment of drug and/or alcohol abuse, substance abuse, mental illness or psychiatric treatment.

** If applicable please indicate what parts of your record and what type of information you do NOT want released:_____

_____.

(Only the MINIMUM NECESSARY of protected health information will be disclosed to accomplish the purpose specified).

Information to be released (Including Dates): Date From: _____ Date: To_____

(Any and All is not a valid response, must have date range)

O D/C Summary O Clinical Summary of Care O Care Coordination Notes O Assessment O Face Sheet

O Treatment Plan O PCP Communication O DLA-20 O MEDS O Vitals/Labs O Progress Notes

O Verbal Communications O Forensic Evaluation O Other: _ _____

(MUST LIST INFORMATION TO BE RELEASED)

The purpose in releasing this information is for: O Treatment and Evaluation O Continuity of Care O Disability

O Legal Purposes O Emergency Contact O Integrated Care/Care Coordination O Other _____

(Describe)

Note: Due to risks associated with faxing confidential health information, VBHCS limits faxing to special circumstances (i.e. client care emergencies, sharing authorized information with other healthcare providers/agencies). I authorize VBHCS to release only specified client health information by facsimile (fax) as indicated.

This information I authorize for release may include information that could be considered information about communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS). I understand that I may revoke this consent at any time. However, I also understand that any release which has been made prior to my revocation and which was made on the basis of this authorization shall not constitute a breach of my Right of Confidentiality. I understand that my records are protected under the federal regulations 42, CFR Part 2, HIPAA and TCA 33 and cannot be disclosed without my written consent unless otherwise provided for in these regulations. I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law and could be re-disclosed. However, if the information contains reference to diagnosis, history, treatment or rehabilitation for drug and/or alcohol abuse and substance abuse, then federal law may prohibit the receiving party from re-disclosure without my consent. I understand that treatment, payment, enrollment, or eligibility benefits will not be conditioned on signing this authorization, and that there are no consequences to me if I refuse to sign this authorization. This authorization is given freely, voluntarily and without coercion. ***This authorization shall expire automatically in twelve (12) months if no date is indicated below.***

CLIENT'S SIGNATURE: _____ **DATE:** _____ **EXPIRATION DATE:** _____

(if less than stated above)

(If the client is either under age or has a guardian appointed by the court, this release must be signed by the client's parent or legal guardian; If the executor, administrator, or personal representative is signing on behalf of a deceased client, proof of this individual's authority to act on behalf of client must be submitted.)

SIGNATURE: _____ **DATE:** _____ **RELATIONSHIP:** _____

(Parent or Legal Guardian, etc.)

WITNESS _____

I am revoking my permission for the above Release of Information. I realize that any information released or shared prior to this revocation does not apply and is only valid after the date below. I am also aware that this may not apply in certain cases of where the laws override this revocation.
(Please refer to VBHCS Notice of Privacy Practices for process).

_____.

(Event or condition)

Client Signature: _____ **Date:** _____ **Witness:** _____

Name: _____ **Medical Record #:** _____