MENTAL HEALTH COOPERATIVE

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

Date of Birth ______________ Social Security # ______________

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

SEND INFORMATION TO/FROM: (place check in box)

Mental Health Cooperative – Chattanooga
801 N. Holtzclaw Avenue, Suite 101
Chattanooga, Tennessee 37404

INFORMATION TO BE RELEASED TO/FROM: (please be specific)

Provider Name/Organization:	Phone:
Address:	Fax:

PURPOSE OF DISCLOSURE: ☐Continued Care ☐Self ☐Specialist ☐Other______________(must complete)

I authorize the release of:

Medical Records from ☐ last 2 years ☐past 6 mos	☐Yes ☐No	Current Medications	☐Yes ☐No
Psychological Evaluations	☐Yes ☐No	Lab Reports	☐Yes ☐No
Treatment Plans	☐Yes ☐No	Admission History, Physical	☐Yes ☐No
H & P, Disc Sum, Labs	☐Yes ☐No	Other (specify)	☐Yes ☐No

**** Please read and initial if you do NOT want certain portions of your records released. I authorize release of all records from Mental Health Cooperative with the exception of the following:**
________Psychiatric & Mental Health Records
________HIV/Aids Records
________Substance Abuse (Drug & Alcohol) Records

If the consumer is unable to sign, please indicate such and the authority to act of the person who is signing for the consumer. This authorization will expire 12 months or less from the date signed, or when services are terminated. This authorization may be revoked by the consumer at any time by sending written notice to our Privacy Official at 275 Cumberland Bend, Nashville, TN 37228, except to the extent that MHC has already taken action in reliance upon it. We will not condition treatment on the completion of the authorization. Also, please be aware that once we disclose this information per your instructions the information is subject to re-disclosure and may no longer be protected by confidentiality rules of the Health Insurance Portability and Accountability Act of 1996. A faxed authorization is as valid as the original.

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

Proprietary: For MHC Use Only---Cannot be duplicated without prior written consent from MHC authorities.

There *is* life after diagnosis!