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)

☐ MHC Metro Davidson County 275 Cumberland Bend Nashville, TN 37228 Ph: (615) 726-3340 (866) 949-7802 Fx: (615) 743-1502	☐ MHC Dickson County 220 Skyline Circle Dickson, TN 37055 Ph: (615) 446-3061 (888) 844-2005 Fx: (615) 446-9567	☐ MHC Montgomery County 201 Uffelman Dr, Ste A Clarksville, TN 37043 Ph: (931) 645-5440 (866) 716-0047 Fx: (931) 648-2701	☐ MHC Sumner County 1078 South Water St. Gallatin, TN 37066 Ph: (615) 230-9663 (888) 882-8696 Fx: (615) 230-8982
☐ MHC Antioch 2711 Murfreesboro Road Antioch, TN 37013 Ph: (615) 365-3160 Fx: (615) 366-4172	☐ MHC Maury County 100 Berrywood Dr Columbia, TN 38401 Ph: (931) 380-3449 (866) 790-8848 Fx: (931) 490-6723	☐ MHC Rutherford County 1203 Memorial Blvd, Suite E Murfreesboro, TN 37129 Ph: (615) 904-6490 (877) 405-0551 Fx: (615) 904-6876	☐ MHC Putnam County 418 N Willow Ave Cookeville, TN 38501 Ph: (931)646-5600 (866) 816-0433 Fx: (931) 646-5649

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.

_____ _____ ☐ Consumer ☐ Other _____

Signature of Consumer or Representative — Date — 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!