MENTAL HEALTH COOPERATIVE

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

_____ _____ Case #: _____

Printed Name of Consumer | Previous Names, If Applicable

_____ _____

Date of Birth | Social Security #

RELEASE TO/FROM: (Authorize Release and Request Information between both listed below)

Mental Health Cooperative	Name: _____
275 Cumberland Bend	Address: _____
Nashville, TN 37228	City, State, Zip: _____
Tel: 615-726-3340	Phone: _____
Fax: 855-311-1617	Fax: _____

Treatment Dates Requested: ☐ Most Recent Encounter ☐ Other: From _____ (MM-DD-YY) to _____ (MM-DD-YY) ☐ Past 6 months ☐ Last 2 years

INFORMATION TO BE RELEASED		
Information Requested in PCP Letter	☐ Yes	☐ No
Admission History, H&P, Discharge Summary, Laboratory Reports	☐ Yes	☐ No
Psychological / Psychiatric Evaluations / Neurological Workup	☐ Yes	☐ No
Treatment Plans and Progress Notes including current medications	☐ Yes	☐ No
School Records	☐ Yes	☐ No
Verbal Communication	☐ Yes	☐ No
Other (specify): _____	☐ Yes	☐ No

PURPOSE OF DISCLOSURE
- ☐ Continued Care
- ☐ Self
- ☐ Specialist
- ☐ PCP Communication and Care Coordination
- ☐ Permission to Provide Services at School
- ☐ Determining Eligibility for third-party Services
- ☐ Other (specify): _____

Initial if you DO NOT want the following portions of your medical records released:

_____ Psychiatric & Mental Health Records
_____ HIV/AIDS Records
_____ Substance Abuse (Drug & Alcohol) Records

☐ I am between the ages of 16 years and 17 years old and DO NOT want communication sent to my parent/legal guardian
☐ DO NOT communicate with my PCP

I understand that this information will not be disclosed to any other agency or individual without my written authorization, except as allowed by law. I also understand that my protected health information, which is disclosed with this release, may be subject to redisclosure by the recipient and no longer protected by law. MHC is not responsible for any alterations made on its medical record copies, which have been released to any party. I understand that I have a right to a copy of this authorization after I sign it. I understand that MHC will not condition treatment on the completion of the authorization. A faxed authorization is as valid as the original. The authorization automatically expires 12 months from the date it was signed or when services are terminated. I understand I can revoke this authorization at any time by sending written notice to MHC's Privacy Official at 275 Cumberland Bend, Nashville, TN 37228, except for disclosures already made based upon my original permission.

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