Centerstone of Tennessee – Release of Information

Client Name: _____ Client ID: _____ DOB: _____

Common Exchange (identity of entity)

- ☐ Parent
- ☐ Spouse
- ☐ Child
- ☐ Sibling
- ☐ Significant Other
- ☐ PCP
- ☐ Attorney
- ☐ Entity (organization)
- ☑ Client
- ☐ Other

Entity Authorizations

- ☑ Release of Information from Centerstone
- ☑ Release of Information to Centerstone

I authorize Information Exchange via

- ☑ Verbal
- ☑ Written
- ☑ Fax
- ☑ Thumb Drive
- ☑ Secure Email
- ☑ Printed

Entity/Name: 32nd Judicial District Mental Health Court

Street: 29 West Main Street

City: Hohenwald State: TN Zip: 38462

Phone: 931-231-8343 (cell) 931-295-3504 Fax: 931-295-3504

Email: mhcdirector@32jdtn.org

Information to be Released:

- ☑ Activity History
- ☑ Assessment (e.g. AIMS, CANS, ANSA, NOMS)
- ☐ Billing Information
- ☑ Care Plan
- ☐ Discharge Summary
- ☑ Facesheet
- ☐ Genetic Testing
- ☑ Lab Tests or other Test Results
- ☑ Medication/Injection Log
- ☐ Other
- ☐ Physical Exam
- ☑ Progress Notes
- ☑ Psychiatric/Psychological Evaluation
- ☐ School Records and Staff Collaboration

Information to be Obtained:

- ☑ Activity History
- ☑ Alcohol or Drug Use Records
- ☑ Assessment (e.g. AIMS, CANS, ANSA, NOMS)
- ☐ Billing Information
- ☑ Care Plan
- ☑ Diagnosis
- ☐ Discharge Summary
- ☑ Facesheet
- ☐ Genetic Testing
- ☑ Laboratory and Other Test Results
- ☑ Medication/Injection Log
- ☐ Other
- ☐ Physical Exam
- ☑ Progress Notes
- ☑ Psychiatric Evaluation/Psychological Evaluation

Indicate Specific Information to Exclude from Authorization:

- ☑ Drug/Alcohol Records
- ☐ Genetic Testing Results
- ☐ HIV/AIDS Records
- ☐ Infectious Disease Records
- ☑ Mental Health Records
- ☐ N/A

Purpose of Information:

- ☐ Audit/3rd
- ☐ Coordination of Treatment
- ☐ Disability/SSA
- ☐ Obtaining Insurance Information
- ☐ Payment
- ☐ Probation
- ☐ State Required Reporting
- ☐ Client Request
- ☐ Department of Corrections
- ☑ Legal Proceedings
- ☐ Other (Specify if Yes is Checked)
- ☐ Social Services

Treatment Dates to Release

- ☑ All Treatment Dates
- ☐ Date Range _____ to _____

Date Released based on today's Date: _____ **Date Release Expires (365 days unless otherwise specified) Date: _____**

HIM Statutes

☒ I understand that my records are protected under state and federal confidentiality statutes and/or regulations, and that the information used or disclosed may be subject to redisclosure by the person(s) receiving it and no longer protected by the federal privacy regulations. I further understand that these records will not be disclosed by Centerstone without my written authorization uless otherwised allowed by state or federal statute, rule, or regulation. I understand the released information may include HIV/AIDS, STD/STI information. I authorize the use of a photocopied, faxed, or scanned presentation of this form as a valid original for the release or disclosure of the information described above. I further authorize Centerstone and its agents to utilize this authorization electronically. I understand that Centerstone is not responsible for any alterations made to Centerstone records that are released to any party. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from Centerstone. I understand that I have a right to a copy of this authoriaztion. I understand that I may revoke this authorization at any time in accordance with 45 CFR 164.508 and 42 CFR Part 2, except to the extent that Centerstone has already acted in reliance on this authorization. A revocation should be in writing and delivered to Health Information Department.

☒ *Sending your personal health information to an email address or fax is not a secure delivery method and may expose your health information to others. By choosing this delivery method, you release Centerstone from any liability involving a potential or actual breach of your health information that has been delivered upon your request to an email address or by fax.

☒ Notice to Recipient of Client Records/Information: Information pursuant to this authorization has been disclosed to you from records which may be protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient. The receiving organization/party is advised and should understand that some or all of the information provided pursuant to this release may not be re-released without further consent of the client/patient except as allowed by statute, rule, or regulation. The receiving organizatin/party will be solely responsible for any unauthorized disclosure or use. This authorization to disclose was developed to comply with the provisions regarding disclosures of medical and mental health records, alcohol and drug abuse records, and other information under: Centerstone Policies; 42 CFR Part 2; Tennessee statutes, regulations, and case law; and HIPAA.

Authorized Signature Description

- ☐ Legal Guardian
- ☐ Power of Attorney
- ☐ Parent
- ☐ Child 16 years old or older
- ☐ Client

_____ _____

Signature of Authorized Person Date Printed name of Authorized Person Date