Kramer Davis
HEALTH

Kramer Davis Clinic – Nashville
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AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Patient' s Name	Date of Birth	Social Security Number

Release of Information From: _____

_____

_____

Release of Information To: _____

_____

_____

TYPE OF INFORMATION RELEASED PERTAINS TO: Mental Health Information, Residential Information, Psychiatric 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): Dates From _____ to _____

☐ D/C Summary	☐ Clinical Summary of Care	☐ Care Coordination Note
☐ Treatment Plan	☐ PCP Communication	☐ Assessment
☐ Face Sheet	☐ DLA-20	☐ Medication History
☐ Medication List	☐ Vitals/Labs	☐ Progress Notes
☐ Hospitalizations	☐ Verbal Communications	☐ Forensic Evaluations
☐ Psychological Testing	☐ Decisional Capacity Examinations	☐ Other:_____

The purpose in releasing this information is for:

☐ Treatment and Evaluation	☐ Continuity of Care	☐ Legal Purposes
☐ Emergency Contact	☐ Integrated Care/Care Coordination	☐ Other:_____

Patient Initials _____ Date of Birth: _____

Note: Due to risks associated with faxing confidential health information, Kramer Davis limits faxing to special circumstances (i.e. client care emergencies, sharing authorized information with other healthcare providers/agencies). I authorize Kramer Davis Health 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 the 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 the 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.

_____ _____

Name of Patient/Guardian/Conservator **Relationship to Patient**

_____ _____

Signature of Patient/Guardian/Conservator **Date**

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

_____

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.

_____

Event or Condition

_____ _____

Name of Patient/Guardian/Conservator **Relationship to Patient**

_____ _____

Signature of Patient/Guardian/Conservator **Date**

_____

Witness