Cedar Grove RTC

AUTHORIZATION FOR RELEASE OF MEDICAL AND/OR MENTAL HEALTH INFORMATION

Cedar Grove RTC is closed as of June 2024

Custodian of Records for closed facilities: Universal Health Services-Nashville Regional Office
Phone: 615-312-5834 Fax: 615-997-1200 Email: nrorecordsrequests@uhsinc.com

To prevent delay of processing your request, please include a copy of a government issued photo ID (i.e. a driver's license) for verification of signature.

Patient Name: _____

Date of Birth: _____ **SSN:** _____

Dates of Treatment: _____

I hereby freely and voluntarily authorize Cedar Grove RTC to:
_____Release/ disclose my protected health information to:

_____
Individual, Facility, or Organization Phone Number & Fax Number

_____
Address City, State, Zip

The purpose of this disclosure is for:

___Insurance purposes	___Medical treatment	___Progress updates
___Educational placement	___Discharge planning	___The patient
___Legal reasons	___Continued treatment	___Other_____

Information to be used or disclosed:

___Dr's Discharge Summary	___Treatment Plans	___Physician Orders
___Psychiatric Evaluation	___Lab/X-ray results	___Substance Abuse Tx
___Mental Status	___Progress Reports	___Aftercare Plan
___History & Physical	___Psychological Assessment	___Discharge Instructions
___Psychological Testing	___Immunization status	___Other_____

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE, or related to mental health, testing, drug, substance, and/or alcohol diagnosis and treatment. I understand that such information is confidential and is protected by federal law. I understand that the provision of health care treatment to me cannot be conditioned upon my agreement to sign an authorization for the disclosure or use of my health information for purposes other than for treatment, payment, and healthcare operations. I understand that the potential exists for health information that is released with my authorization to be re-disclosed by the recipient, and to be no longer protected by the Federal HIPAA law. I understand that I have the right to revoke this authorization at any time by giving written notice to Shadow Mountain and/or other facility privacy officer, except to the extent that action has already been taken in reliance on it. The authorization will expire 180 days following discharge, or following signature date unless another date or condition is specified. Other date or condition specified:

SIGNATURES

Patient – When applicable by law or hospital policy **Date**

Guardian or Representative **Relation to Patient** **Date**

Witness

*Drug and alcohol records are protected by Federal confidentiality ruling (42 CFR part 2) and require written consent to disclose this information unless otherwise permitted by 42 CFR part 2. Further disclosure is prohibited without written consent by the person to whom the information pertains unless otherwise permitted by the law. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.