AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

ClearPath

Instructions: Fill in the appropriate information in each applicable section. Sign, date, and return the form.
Incomplete forms will be returned to you unprocessed. A separate authorization must be completed for each request.

Patient Name	DOB	Phone
Name of Authorized Representative *(if applicable)*		
Street Address		
City	State	Zip Code

I HEREBY AUTHORIZE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS FOLLOWS:

DISCLOSED ☐ BY ☐ TO		**DISCLOSED ☐ BY ☐ TO**	
ClearPath Behavioral Health Clinic			
1639 Medical Center Pkwy, Suite 202			
Murfreesboro, TN 37129			
P: 615-447-9880	*F: 615-410-4322*	Phone:	Fax:

By signing below, I hereby authorize the covered entity indicated above, to disclose information contained in the medical and financial record of the patient identified above, which includes information that may be stored in a paper and/or other electronic format. However, such notes may contain information on general medical care; alcohol and drug abuse treatment; psychological and social work counseling; human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS), or AIDS related complex. Including communicable diseases or infections, sexually transmitted diseases, venereal diseases, tuberculosis and hepatitis; demographic information; and treatment received at other health care facilities. Disclosure shall be limited to the following specific information contained in my records and/or obtained during the course of my diagnosis and treatment.

PURPOSE OF THIS DISCLOSURE:

☐ Transfer Care	☐ Aid in Treatment	☐ Psychological Report
☐ Follow-up Care	☐ Discharge Planning	☐ Aid in Financial Account Activity
☐ Inform Family	☐ Update Medical Record	☐ Other *(specify)*:
☐ Referral Source	☐ Employer	
☐ Legal / Court System	☐ Application for Provider Coverage	

THE FOLLOWING INFORMATION IS REQUESTED:

☐ History & Physical	☐ Laboratory Reports	☐ Discharge Instructions
☐ Psychiatric Evaluation	☐ Radiology Reports	☐ Financial Account Information
☐ Practitioner Orders	☐ Immunization Records	☐ Other *(specify)*:
☐ Practitioner Progress Notes	☐ Medication Records	
☐ Discharge Summary	☐ Treatment / Care Plan	

I understand that the information in my health record may include information related to sexually transmitted disease, immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released / obtained. (include dates where appropriate):

Alcohol, Drug, Substance Abuse Records:	**HIV Testing and Results:**	**Mental Health Records:**
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

This authorization is valid only if received within 60 days of being signed. This authorization will expire at the time of disclosure of requested information or on _____ *(date cannot be more than 180 days from date signed).* I understand I make revoke this authorization at any time. Revocations to this authorization must be presented in writing. Revocation will not apply to information disclosed prior to receiving a written revocation. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and may no longer be protected by federal and state privacy laws and regulations. I understand that ClearPath Clinic will not condition my treatment, payment, enrollment or eligibility for benefits on whether I provide this authorization.

By signing below I acknowledge that I am aware of the confidential and/or privileged nature of the information being disclosed, and understand the benefits and/or disadvantage of disclosing such information. I hereby release above Facility, its affiliates and its agent and representatives, (including collection agencies) from all legal liabilities that may result from the release of this information according to this request. I also expressly consent and authorize to be contacted by the phone number provided (cellular or residential) by any type of voice method and by auto-dialer technology for any permissible purpose.

Signature of Patient or Authorized Representative	***Relationship***	***Date***

Notice to Recipient: This authorization provides for a ·release of information about an individual whose confidentiality is protected by federal and state laws and regulation, including the Health Insurance Portability and Accountability Act of 1996 (45 C.F.R. §160-164) as well as 42 C.F.R part 2 and 42 U.S.C. §. §290dd-2, and state confidentiality laws. No information disclosed from this authorization may be re-disclosed without the specific written consent of the individual about whom such information pertains.