

Phone: (423) 648-4951

Toll Free: 877-730-5614 Fax: (423) 490-0410

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Please indicate the purpose with l To Excl		To Release to	To Obta	in from
Name of Person / Facility / Patient Rep	presentative	Title / Relationship	Telephone No.	Fax No
Address		City	State	Zip
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X Diagnosis	X _ Atte	ndance or dates seen	X _ Other	– Explain:
X _ Medical history	X _ Psy	chosocial history		
X _ Progress notes	X Sun	nmary of psychological	testing	
X _ Evaluations	X _ Verl	bal		
This information is required for (pla	ce " x " to all tha	t apply).		
Soc Sec / Disability	Insเ	ırance	Other	– Explain:
X Continuation of Care	Leg	al Purposes		
X Coordination of services	X Trea	atment and evaluation		
Patient's Name	Date of Birth	Social Securi	itv No.	Telephone No.
Patient's Name	Date of Birth	n Social Securi	ity No.	Telephone No.
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Name of Person / Facility / Patient Repres	sentative	Title / Relationship	Telephone No.	Fax No.
Address		City	State	Zip
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Signature of witness:			Date:	



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X Progress notes	X Summary	of psychological	testing		
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Relationship to patient: Signature of witness:			→ Date: → Date:		(updated: 11/20/19)
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Signature of witness:			<mark>→</mark> Date:	(undated: 14/20/40)



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X All medical records	X _ Tre	atment plans	X Medicat	ion(s)
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X _ Medical history	X _ Psy	chosocial history		
X Progress notes	X _ Sur	mmary of psychologica	I testing	
X _ Evaluations	X _ Ver	bal bal		
This information is required for (p	lace " x " to all tha	at apply).		
Soc Sec / Disability	Ins		Other –	Explain:
X Continuation of Care		gal Purposes		
X_ Coordination of services		atment and evaluation		
Address		City	State	Zip
I understand that my record		<u>-</u>	y mental health, su	ıbstance use o
 My treatment, payment of eliginary refuse to sign this authorized that this authorized taken in reliance upon it. The information used or discland no longer protected by Foundary see and obtain a copy of Fees/charges will comply with expiration. This authorized and covers this treatment per use of copies: A copy of this I have read the above and authorized that DCS has rights for the sign of this payment. 	orization and that in the cation may be revolved by the cation of the information shall expire sizion of the information of the cation shall expire sizion of the information may atthorize the disclose	t is strictly voluntary. bked by me at any time exhe authorization may be services. described on this form, for lations applicable to release (6) months from the data be utilized with the same sure of the protected health	scept to the extent the subject to re-disclosu or a reasonable fee, if ase information. the signed below, unle	at action has be re by the recipi I request it. ss specified original.
		⇒		
Print Name		Signature of Patient / L		
Relationship to patient:			→ Date:	
			Date.	
Signature of witness:			Date:	



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I,		hereby request and	authorize _	SECOE
Please indicate the purpose with <mark>II</mark> To Exch	NITIALS: ange with	To Release to	To O	btain from
Name of Person / Facility / Patient Rep	resentative	Title / Relationship	Telephone I	No. Fax No.
Address		City	State	Zip
I authorize the release/exchange of	the following m	edical records and info	ormation (plac	ce " x " to all that appl
X — All medical records	_	tment plans	X Me	
X Diagnosis		ndance or dates seen		` '
X Medical history		chosocial history		
X_ Progress notes	•	mary of psychological		
X _ Evaluations	X _ Verb			
This information is required for (plac	e " x " to all that	apply).		
Soc Sec / Disability	Insur		Oth	ner – Explain:
X Continuation of Care	Lega	al Purposes		'
X Coordination of services	_	tment and evaluation		
Address I understand that my records initials) dependency, sexuality, s				
 My treatment, payment of eligibil I may refuse to sign this authorized in understand that this authorization taken in reliance upon it. The information used or disclosed and no longer protected by Focusion in the information used or disclosed and no longer protected by Focusion in the information used or disclosed and no longer protected by Focusion in the information in	cation and that it it on may be revoked pursuant to the its Psychiatric Selbe information de I laws and regulant shall expire six only. horization may borize the disclosure.	is strictly voluntary. ed by me at any time exceed authorization may be stricted. escribed on this form, for ations applicable to release (6) months from the date the utilized with the same of the protected health	cept to the externation areasonable formation. esigned below,	ent that action has be closure by the recipion fee, if I request it. unless specified s the original.
Print Name	_	Signature of Patient / Le	anal Guardian /	Patient Representat
Relationship to patient:		_		Tatient Representat
			<u> </u>	(undated: 11/20/19
Signature of witness:			<u></u>	(undated: 11/20/10



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request and	authorize SEC	OE
Release to	To Obtain	from
Relationship	Telephone No.	Fax No.
	State	Zip
ans	X Other – E testing	on(s)
Social Secur	ity No. To	elephone No.
	State	Zip
	/ mental health, sub al HIV (AIDS) relate	
voluntary. at any time exception may be so this form, for olicable to releate the form the date with the same	n signing this authorize cept to the extent that ubject to re-disclosure a reasonable fee, if I se information. It is signed below, unless the continuous as state on information as state	t action has been by the recipied request it. s specified
	egal Guardian / Patiei	-
	Date:	
	⇒ Date:	(updated: 11/20/19)
_		Date:

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Fax: (423) 490-0410

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