Focus Southeast Center of Excellence

Authorization to Exchange, Request or Release Information

I, _____, hereby request and authorize **SECOE**

Please indicate the purpose with **INITIALS**:

To Exchange with_____ To Release to_____ To Obtain from_____

Name of Person / Facility / Patient Representative	Title / Relationship	Telephone No.	Fax No.

Address	City	State	Zip

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__X__ All medical records	__X__ Treatment plans	__X__ Medication(s)
__X__ Diagnosis	__X__ Attendance or dates seen	__X__ Other – Explain: _____
__X__ Medical history	__X__ Psychosocial history	_____
__X__ Progress notes	__X__ Summary of psychological testing	_____
__X__ Evaluations	__X__ Verbal	_____

This information is required for (place "**x**" to all that apply).

_____ Soc Sec / Disability	_____ Insurance	_____ Other – Explain: _____
__X__ Continuation of Care	_____ Legal Purposes	_____
__X__ Coordination of services	__X__ Treatment and evaluation	_____

Patient's Name	Date of Birth	Social Security No.	Telephone No.

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- I have read the above and authorize the disclosure of the protected health information as stated.

☐ Verified that DCS has rights for educational care.

Print Name _____ **Signature of Patient / Legal Guardian / Patient Representative**

Relationship to patient: _____ **Date:** _____

Signature of witness: _____ **Date:** _____

(updated: 11/20/19)

6400 Lee Hwy. – Suite 110
P.O. Box 22367
Chattanooga, TN 37422

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

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