



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.
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Address	City	State	Zip
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I authorize the release/exchange of the following medical records and information (place "x" to all that apply).

- | | | |
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| <input checked="" type="checkbox"/> All medical records | <input checked="" type="checkbox"/> Treatment plans | <input checked="" type="checkbox"/> Medication(s) |
| <input checked="" type="checkbox"/> Diagnosis | <input checked="" type="checkbox"/> Attendance or dates seen | <input checked="" type="checkbox"/> Other – Explain: _____ |
| <input checked="" type="checkbox"/> Medical history | <input checked="" type="checkbox"/> Psychosocial history | _____ |
| <input checked="" type="checkbox"/> Progress notes | <input checked="" type="checkbox"/> Summary of psychological testing | _____ |
| <input checked="" type="checkbox"/> Evaluations | <input checked="" type="checkbox"/> Verbal | _____ |

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

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|--|--|---|
| <input type="checkbox"/> Soc Sec / Disability | <input type="checkbox"/> Insurance | <input type="checkbox"/> Other – Explain: _____ |
| <input checked="" type="checkbox"/> Continuation of Care | <input type="checkbox"/> Legal Purposes | _____ |
| <input checked="" type="checkbox"/> Coordination of services | <input checked="" type="checkbox"/> Treatment and evaluation | _____ |

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I understand that my records may contain information regarding my mental health, substance use or dependency, sexuality, suicidality and may contain confidential HIV (AIDS) related information.

- My treatment, payment of eligibility for benefits may not be conditioned on signing this authorization.
- I may refuse to sign this authorization and that it is strictly voluntary.
- I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it.
- The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by Focus Psychiatric Services.
- I may see and obtain a copy of the information described on this form, for a reasonable fee, if I request it.
- Fees/charges will comply with all laws and regulations applicable to release information.
- EXPIRATION: This authorization shall expire six (6) months from the date signed below, unless specified _____ and covers this treatment period only.
- Use of copies: A copy of this authorization may be utilized with the same effectiveness as the original.
- 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 _____

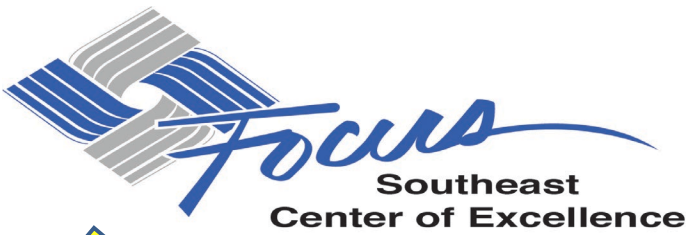
Relationship to patient: _____ Date: _____

Signature of witness: _____ Date: _____

(updated: 11/20/19)

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

Phone: (423) 648-4951
Toll Free: 877-730-5614
Fax: (423) 490-0410



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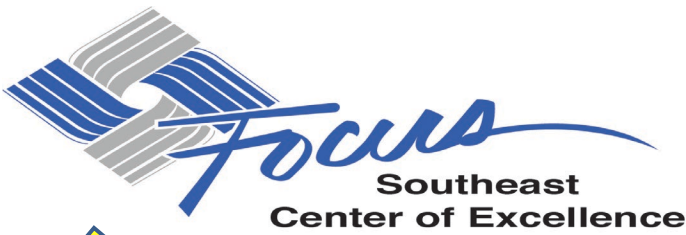
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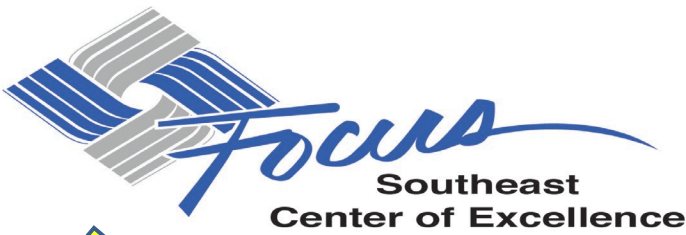
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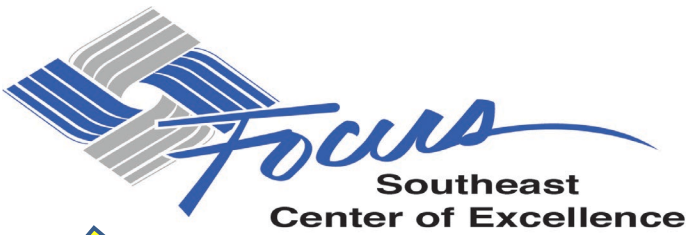
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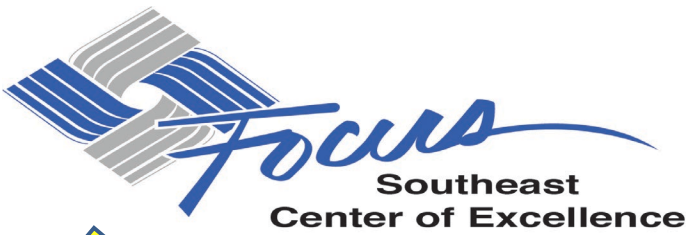
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Toll Free: 877-730-5614
Fax: (423) 490-0410



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.
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Address	City	State	Zip
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I authorize the release/exchange of the following medical records and information (place "x" to all that apply).

- | | | |
|---|--|--|
| <input checked="" type="checkbox"/> All medical records | <input checked="" type="checkbox"/> Treatment plans | <input checked="" type="checkbox"/> Medication(s) |
| <input checked="" type="checkbox"/> Diagnosis | <input checked="" type="checkbox"/> Attendance or dates seen | <input checked="" type="checkbox"/> Other – Explain: _____ |
| <input checked="" type="checkbox"/> Medical history | <input checked="" type="checkbox"/> Psychosocial history | _____ |
| <input checked="" type="checkbox"/> Progress notes | <input checked="" type="checkbox"/> Summary of psychological testing | _____ |
| <input checked="" type="checkbox"/> Evaluations | <input checked="" type="checkbox"/> Verbal | _____ |

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

- | | | |
|--|--|---|
| <input type="checkbox"/> Soc Sec / Disability | <input type="checkbox"/> Insurance | <input type="checkbox"/> Other – Explain: _____ |
| <input checked="" type="checkbox"/> Continuation of Care | <input type="checkbox"/> Legal Purposes | _____ |
| <input checked="" type="checkbox"/> Coordination of services | <input checked="" type="checkbox"/> Treatment and evaluation | _____ |

Patient's Name	Date of Birth	Social Security No.	Telephone No.
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Address	City	State	Zip
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I understand that my records may contain information regarding my mental health, substance use or **(initials)** dependency, sexuality, suicidality and may contain confidential HIV (AIDS) related information.

- My treatment, payment of eligibility for benefits may not be conditioned on signing this authorization.
 - I may refuse to sign this authorization and that it is strictly voluntary.
 - I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it.
 - The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by Focus Psychiatric Services.
 - I may see and obtain a copy of the information described on this form, for a reasonable fee, if I request it.
 - Fees/charges will comply with all laws and regulations applicable to release information.
 - EXPIRATION: This authorization shall expire six (6) months from the date signed below, unless specified _____ and covers this treatment period only.
 - Use of copies: A copy of this authorization may be utilized with the same effectiveness as the original.
 - 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)

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