River Crest Hospital

AUTHORIZATION FOR RELEASE OF MEDICAL AND/OR MENTAL HEALTH INFORMATION

River Crest Hospital is closed as of September 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

Patient Name: ______________________________ Birth Date: ______________
Maiden/Prior Names: ______________________ Current Phone #: ______________
Current Address: ______________________________ Last 4 of SS#: __________

To be released to

☐ Self (address above)

☐ ______________________ (____)____________ ______________________
Individual/Agency/Organization Telephone Number Street Address

______________________ (____)____________ ______________________
Relationship to Patient Fax Number City State Zip Code

Via (only when released to): ☐ Mail ☐ Fax ☐ Email: ______________________

I am requesting disclosure of my protected health information for the following purpose:

☐ Continuing Care ☐ Disability Determination ☐ Child Custody ☐ Personal Use
☐ Academic ☐ Legal Investigation ☐ Billing/Insurance ☐ Other: ______________

Dates of Service Requested: ______________________________

☐ **I authorize the release of the following information <u>including</u> all records that include any substance use disorder and/or substance use disorder treatment records,**

OR

☐**I authorize the release of the following information <u>excluding</u> all records that include any substance use disorder and/or substance use disorder treatment records,**

Only the information and records indicated below (check all that apply and /or specific if Other is checked):

☐ Continuity/Transition of Care Packet ☐ Progress Notes ☐ HIV Test Results- AIDS Treatment Records
☐ Psychiatric Evaluation ☐ Physician Orders ☐ Other: ______________
☐ History and Physical ☐ Lab/Diagnostic Reports
☐ Discharge Summary

This authorization will expire on ____/____/20____. (If not indicated, authorization will expire <u>one year</u> from signature date)
This form must be completed in full before signing:

______________________ ______________
Patients signature (required for ages 16 and older) Date/Time Signed

______________________ ______________ ______________
Parent/Legal Guardian signature (if applicable) Relationship to Patient Date/Time Signed

______________________ ______________
Witness signature/Credentials Date/Time Signed

This authorization is intended to allow River Crest Hospital to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure.

You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by federal regulations. Your right to inspect and receive a copy of the information that is to be disclosed. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with the copying of my information in the processing of this request.

______________________ ______________
Revocation Signature Date/Time

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.