FOUNDATIONS RECOVERY NETWORK
CONSENT TO RELEASE CONFIDENTIAL INFORMATION
FRN Nashville Out Patient - 815

Patient Name _____ Birthdate _____ ID _____

Patient Street Address _____ City _____ State _____ Zip _____

Patient Phone _____ SS# _____

Releasing information to: Name/Organization _____ Phone _____

Street Address _____ City _____ State _____ Zip _____

I authorize Foundations Nashville to release to ___ and receive____ from the above person/agency the following information:

☐ Y ☐ N Admission Face Sheet	☐ Y ☐ N X-ray Reports	☐ Y ☐ N Continuing Care Plan
☐ Y ☐ N History and Physical Form	☐ Y ☐ N Psychological Evaluation	☐ Y ☐ N Laboratory Reports
☐ Y ☐ N Family Assessment	☐ Y ☐ N Assessment Report	☐ Y ☐ N Drug Screens
☐ Y ☐ N Financial Information	☐ Y ☐ N Progress Notes	☐ Y ☐ N Physician Orders
☐ Y ☐ N Treatment Update / Status – Verbal	☐ Y ☐ N Nursing Assessment	☐ Y ☐ N Biopsychosocial Questionnaire
☐ Y ☐ N Treatment Update / Status – Written	☐ Y ☐ N Medication List	☐ Y ☐ N Psychiatric Consult/Evaluation
☐ Y ☐ N Treatment Plans and Reviews	☐ Y ☐ N Consent Forms	☐ Y ☐ N Discharge Summary

☐ Y ☐ N Correspondence (Specify) _____
☐ Y ☐ N Other (Specify) _____
☐ Y ☐ N Referral source
For the purpose of: Participation in patient's treatment_____ Emergency Contact_____ Coordination of care_____

In addition to verbal and written reports, I also agree this information may be released / exchanged: Electronically ___ Fax ___

Medical records frequently contain confidential remarks furnished by the patient, patient's family and staff. If, in the judgement of the medical staff, disclosure of such information will be harmful to the patient, release of such information will be withheld. I understand that information received or medical records prepared after this release form is completed, regarding my condition and the services I have received in the course of my diagnosis and treatment, may be subject to release to authorized parties in compliance with federal and state law and the terms of this form. I understand that the records released may contain alcohol and drug treatment, AIDS/HIV or psychiatric/psychological/psychosexual information. I understand this communication will reveal my presence as a patient in a treatment facility.

This release demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPPA), Standards for Privacy of individually identifiable Health Information (Privacy Standards), 45 CFR 160 & 164 and Federal Regulations 42 CFR Part 2 and all federal regulations and interpretive guidelines promulgated thereunder. The recipient of this information may not disclose this information unless another authorization is obtained from me or unless such disclosure is required or permitted by law (42 CFR Part 2). I understand once the requested information is disclosed, the HIPAA Privacy Regulations may no longer protect it should the recipient disclose it.

This consent for information is given freely, voluntarily and without coercion. I understand that I may revoke this consent to release information in writing at any time, except for information that has already been released under this valid consent. In any event, upon fulfillment of the above-stated purpose, this consent will automatically expire one year from the date signed. I further understand that Foundations Recovery Network reserves the right to notify the above-named person, corporation o agency of my revocation in the event that I revoke this consent to release information.

_____ _____
Patient Signature Date

_____ _____
Staff signature Date

Foundations Recovery Network - Nashville Out Patient Facility - is now closed as of 12-2020.

Please contact UHS-NRO for all Records requests:
UHS-Nashville Regional Office
1000 Health Park Dr. Bldg. 3 Ste. 300
Brentwood, TN 37027

Email: nrorecordsrequests@uhsinc.com
Fax: 615-997-1200
Phone: 615-312-5834

To prevent delay of processing your request please include a copy of your government issued photo ID (i.e. a driver's license) for signature verification.