Foundations Recovery Network
Records Request
3930 4th Ave. Ste. 301
San Diego, CA 92103

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.

Consent/Authorization to Use or Release Protected Health Information (PHI)

I authorize FRN San Diego Treatment Center to use or to release the records checked below to:

FRN San Diego Treatment Center is now closed as of 07/2019. UHS-NRO Office will process the medical records.
1000 Health Park Dr. Bldg. 3 Ste. 300 Brentwood TN 37027 Email: nrorecordsrequests@uhsinc.com Fax: 615-997-1200

Company Name/Contact _____

Address _____ City _____ State _____ ZIP _____

Phone _____ Fax _____ Email _____

Patient Name _____ DOB _____ Last 4 of SSN _____

Address _____ City _____ State _____ ZIP _____

Phone _____

How may we release your information? (CHECK ALL THAT APPLY) ☐ Fax ☐ Email ☐ Mail

Specific dates of treatment to be released _____ OR All dates of treatment (check here) ☐

Information to be released (CHECK ALL THAT APPLY)

- ☐ Pre-Admission/Admission Documents
- ☐ Insurance/Accounting/Billing Records
- ☐ Clinical/Social History, Treatment Plans
- ☐ Laboratory/Radiology Reports
- ☐ Mental Health/Psychiatric History and Records
- ☐ Other specific records (specify):_____
- ☐ Medical/Nursing History and Records
- ☐ Discharge and Aftercare Documents
- ☐ Administrative Documents (Consents, Releases, etc.)

For the following purpose(s) (CHECK ALL THAT APPLY)

- ☐ Coordination of Care/Treatment Planning
- ☐ Insurance Reimbursement/Appeals/Grievances
- ☐ Personal Use
- ☐ Other Purposes (please specify): _____
- ☐ School
- ☐ Employment
- ☐ Legal Purposes

- Unless revoked, this authorization will remain in effect for 12 months from the date it is signed or until the date specified here: _____
- A photocopy or email copy shall be as valid as the original authorization.
- I understand that Substance Abuse records may include medical information relating to sensitive issues such as HIV/AIDS status and/or sexually transmitted diseases. With this authorization, I agree to allow such information to be released (if applicable) unless expressly prohibited by me here.
- ____ DO NOT release any HIV/AIDS or sexually transmitted disease information **(I realize this may result in some requested documentation not being released.**
- I understand that I have the right to revoke this authorization both orally and in writing by providing a signed, written Notice of Revocation From FRN San Diego However, the revocation will not be effective to the extent that FRN San Diego has used or disclosed information pursuant to this authorization before receipt of the revocation.
- FRN San Diego may not condition treatment based upon signature of this authorization.
- Federal Confidentiality Rules prohibit re-disclosure of information from drug and alcohol abuse records. However, HIPAA requires that FRN San Diego notify me of the potential that information disclosed pursuant to this authorization might be re-disclosed by the recipient and is no longer protected by the HIPAA rules.

_____ _____
Patient Signature Date

_____ _____
Authorized Representative's Signature Date
Authorized Representative's Relationship to Patient: _____