This facility is now closed as of 3-2020, for all records requests please contact:

UHS-Nashville Regional Office 1000 Health Park Dr. Bldg. 3, Ste. 300 Brentwood, TN 37027

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

THE OAKS AT LAPALOMA

Confidential Consent for Release of Information

Patient Name: _____ DOB: _____

I hereby authorize the release of the following information: *(check all that apply)*

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.

Yes	No	
☐	☐	Medical history, examinations, laboratory tests and treatment reports
☐	☐	Psychological test results, psychiatric evaluation and neurological workup
☐	☐	Social history, including family, education, employment, legal issues and drugs use
☐	☐	Summary of previous mental health and substance abuse treatment
☐	☐	Periodic reports or current treatment progress including attendance and participation
☐	☐	Discharge and aftercare planning
☐	☐	TB skin test and/or chest X-ray results
☐	☐	Specify other documentation requested: _____

From: **THE OAKS AT LAPALOMA** 2009 LAMAR AVE. MEMPHIS TN 38114

To, _____

City and State: _____

Phone: _____ Fax: _____ Email: _____

(Complete a separate release form for each contact)

☐ Emergency Contact ☐ Referral Source ☐ PO/Attorney ☐ Employer ☐ Insurance Co ☐ Therapist-Psychiatrist

☐ PCP ☐ Hospital Stay ☐ ER Visit ☐ Detox Center ☐ IOP ☐ Other: _____

For requesting records, please provide approximate date of service: _____

I understand that this information will be used for the following purpose(s): *(check all that apply)*

Yes	No	
☐	☐	Develop a diagnosis, treatment and rehabilitation plan
☐	☐	Coordinate medical, psychological, and social rehabilitation processes
☐	☐	Process insurance claims for services provided *(diagnosis, number of visits, modalities and expected length of stay)*
☐	☐	Specify other purpose: _____

Forms in which information may be released/exchanged: ____ Fax or _____ Email

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

This consent for release of information is given freely, voluntarily, and without coercion. I understand that my records are protected under the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42-CFR, Part 2, and no information may be re-disclosed by either party to any other individual or agency unless by my written consent. I further understand that this authorization may be revoked at any time by my written statement and automatically expires at the end of twelve (12) months from date of signature on form.