Brookhaven retreat®
Comprehensive Recovery for Women

authorization for request of confidential information

RE: ______________________________ DOB: ____________________

I hereby authorize ____ (the "Record Keeper") with an address of ____________________________(street), ____________________(city), __________(state) ____________(zip), and a phone number of (________)________________ to release copies of the following confidential information to Brookhaven Retreat, LLC ("Brookhaven Retreat"), 1016 I.C. King Road, Seymour, TN 37865, Phone: 865-573-3656, Fax: 865-609-6216 and/or its representatives solely for the purpose of obtaining treatment from Brookhaven Retreat. I understand that my records may be protected under Federal Confidentiality regulations (42 CFR Part 2) and other applicable state and federal law and cannot be disclosed without my written consent unless otherwise provided for in the applicable statutes and regulations. I understand that my medical record may contain information concerning my psychiatric and psychological condition, drug or alcohol abuse, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions. (Under the Mental Health Code, release of mental health records must be germane to the purpose and need for disclosure.)

I SPECIFICALLY AUTHORIZE RELEASE OF THE FOLLOWING:

- ☐ Medical History & Physical Examination
- ☐ Physician Notes
- ☐ Staff conference/Treatment Plans & reviews
- ☐ Discharge Summary
- ☐ Consultation Reports
- ☐ Entire Contents of my Client Chart/Medical Record
- ☐ Disclosure of Treatment Progress
- ☐ Admission/Evaluation Summary(ies)
- ☐ Psychological Evaluation
- ☐ Physician Orders
- ☐ Discharge Treatment Summary
- ☐ Laboratory & X-ray reports
- ☐ Acknowledgement of Presence
- ☐ Physician's Notes
- ☐ Other: ____

I understand that I may revoke this authorization at any time by providing a signed, written notice to the Record Keeper. I understand that I cannot revoke this authorization to the extent this authorization has been previously relied upon. Unless previously revoked, this authorization will terminate one year from the completion of my treatment at Brookhaven Retreat or within one year of completion of this request, whichever is later. I understand that I am not required to sign this authorization and that my treatment, payment, enrollment or eligibility for benefits is not conditioned on my execution of this authorization.

______________________________ ____________________
Client Signature Date

______________________________ ____________________
Staff Signature & Credentials Date

PROHIBITION ON REDISCLOSURE

"This information has been disclosed to you from records protected by Federal Confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client."