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. 400 Brentwood, TN 37027
Phone: 615-312-5834 Fax: 615-997-1200 Email: nrorecordsrequests@uhsinc.com

FOUNDATIONS
RECOVERY NETWORK
MEMPHIS

CONSENT/RELEASE OF INFORMATION

Patient Name: _____ DOB: _____

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

Yes	No	
☐	☐	Medical/Nursing History and Records
☐	☐	Mental Health/Psychiatric History and Records
☐	☐	Clinical/Social History, Treatment Plans, Progress Notes
☐	☐	Substance Abuse History and Records
☐	☐	Periodic Reports of Attendance/Participation
☐	☐	Insurance/Accounting/Billing Records
☐	☐	Discharge and Aftercare Documents
☐	☐	Laboratory/Radiology Reports
☐	☐	Disability/FMLA Forms
☐	☐	Administrative Documents (Consents, Releases, Etc)
☐	☐	Other specified documentation: _____

To/From: Foundations Memphis, 1083 W Rex Road, Memphis, TN 38119
Att: Medical Records

To/From: _____ **Address:** _____

Relationship:
(There should be 1 release form for each relationship)

OP/Therapist-Psych ☐ Referral ☐ PCP ☐ In Case of Emergency
Insurance Company ☐ PO/Attorney ____ Other: _____

Phone: _____ **Fax:** _____ **Email:** _____

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

☐	☐	Coordination of Care/Treatment Planning
☐	☐	Insurance Reimbursement/Appeals/Grievances
☐	☐	Personal Use
☐	☐	School
☐	☐	Employment
☐	☐	Legal Purposes
☐	☐	Emergency Contact Only
☐	☐	Specify other purpose: _____

☐ **DO NOT release HIV/AIDS or Sexually Transmitted Disease Information**

Forms in which information may be released/exchanged:
☐ Verbal ☐ Written/Photocopied ☐ Electronic/Email ☐ Fax

_____ _____
Patient Signature Date

_____ _____
Foundations Memphis Staff 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.