## Authorization to Release Information

of Mental Health Evaluation Drug/Alcohol Testing

I,(Name of Resident), whose Date of Birth is,
hereby authorize   [Erlanger Work Force]   [specify other:]
, to disclose to The University of Tennessee, Graduate Medical Education and its administrators, including the Associate Dean/DIO, Director of GME, Program Director, as well as (Name of Person or Title of Person or Organization)
Description of Information to be Disclosed
Assessment Diagnosis Psychosocial Evaluation Treatment Plan or Summary
Drug/alcohol test results
☑ Current Treatment Update ☑ Presence/Participation in Treatment
Collateral Interview for Evaluation ☑ _ Discharge Summary ☑ _ Continuing Care Plan
☑ Progress in Treatment ☑ Demographic Information
Psychotherapy Notes* (*Cannot be combined with any other disclosure)
OtherOther
Revocation I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to the UT College of Medicine GME. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization. I further understand that if I revoke this Authorization that I will be subject to the discipline under GME Policy #740, Fitness for Practice.
Expiration Unless sooner revoked the authorization expires six months from this date on: N/A or as otherwise indicated:
Form of Disclosure The disclosure may be made in any manner appropriate and consistent with applicable law, including but not limited to, verbal, in paper format or electronically.
Redisclosure I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.
Signature of Resident Date
Check here if Resident refuses to sign this Authorization
Signature of Staff Witness Date