



The Recovery Center – Closed as of 6/2025

Custodian of Records for closed facilities:

Universal Health Services-Nashville Regional Office

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

Patient Name: _____ Birth Date: _____

Maiden/Prior Names: _____ Current Phone #: _____

Current Address: _____ Last 4 of SS#: _____

*****All sections above and below must be filled out to be considered valid**

To be released/requested from: Self (address above)

_____ (_____) _____ (_____) _____
Name of Person/Agency/Organization Telephone Number Fax Number Email

Address City State Zip Code Name / Attention to (if applicable)

Release information/records via: Mail Fax Email: _____

I am requesting disclosure of my protected health information for the following purpose:

- Continuing Care Disability Determination Child Custody Personal Use
- Academic Legal Investigation Billing/Insurance Other: _____

Dates of Service Requested: _____
(if unsure of exact dates put a specific time range ex. June 2025 – July 2025 or if needing all records put all 'all dates of services')

I authorize the release of the following information including all records that include any substance use disorder and/or substance use disorder treatment records, or

I authorize the release of the following information excluding all records that include any substance use disorder and/or substance use disorder treatment records, or

Only the information and records indicated below (check all that apply and /or specific if "Other is checked):

- | | | |
|--|--|--|
| <input type="checkbox"/> Discharge Safety/Planning – verbal only | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Billing Records |
| <input type="checkbox"/> Continuity/Transition of Care Packet | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> HIV Test Results and AIDS Treatment Records |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Physician Orders | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Medications / MAR | <input type="checkbox"/> Other: _____ |

This authorization will expire on ____/____/20____. (If not indicated, authorization will expire one year from signature date)

This form must be completed in full before signing: **The authorizing signature must be a 'wet signature' and cannot be electronic.

Patient's signature (required for 18 ages and older) Date/Time Parent/Legal Guardian signature (if applicable) Date/Time

Witness signature/Credentials Date/Time Signed Relationship to Patient

This authorization is intended to allow The Recovery Center to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure.

You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by federal regulations. Your right to inspect and receive a copy of the information that is to be disclosed. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with copying my information in the process of this request.

Revocation Signature Date/Time Witness signature/Credentials Date/Time