Clarksville Behavioral Health, LLC
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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I. Information About the Use or Disclosure

I, hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and that I may refuse to sign this authorization, and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.

I, _____ whose birth date is _____
(patient's name)
give permission to Clarksville Behavioral Health, LLC ("CBH") to release my health-related information to/from:

_____
(Name and phone number of person/agency/doctor to which disclosure is being made)

Information to be released: _____ Report _____Therapy Notes _____ All Others

This authorization will expire _____ (indicate date, or an event relating to you personally or to the purpose of the authorization), and no later than one year from the date signed.

II. Important Information About Your Rights

I have read and understood the following statements about my rights:

- I understand that the person or organization that receives this information may not have, or obey, the same obligations to protect privacy that CBH does under state and federal laws.
- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization, in writing, but the revocation will not have any effect on any actions that the entity took before it received the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity. I have the right to seek assurances from the above-named persons/organizations authorized to receive the information that they will not redisclose the information to any other party without my further authorization.
- I further acknowledge that the information to be released was fully explained to me and that this consent is given of my own free-will. I release the above parties from any legal liability resulting from the release of this information. This release may include any or all records acquired by the above parties.

III. Signature of Patient or Patient's Representative

_____ _____
Signature of Patient or Patient's Representative Date of Consent

PRINTED NAME OF THE INDIVIDUAL'S REPRESENTATIVE:

_____

Relationship to the Patient, including authority for status as Representative:

Circle one: **GUARDIAN, CONSERVATOR, POWER-OF-ATTORNEY**