HERMITAGE HALL
"Turning over a new leaf"

RELEASE OF INFORMATION

Patient's Name	Birth date	Social Security Number
_____ _____	_____	_____

Information Disclosed To/From: **Reviewing Facilities/Funding Entities for Authorization Purposes**

SEND INFORMATION TO: **Hermitage Hall**
1220 8th Avenue South
Nashville, TN 37203

OR

Confidential Referral FAX Number: **615-250-2388**
E-mail:

Network Facilities to Review: Cedar Grove, Compass Intervention Center, Hermitage Hall, Laurel Heights, Natchez Trace Youth Academy, Mountain Youth Academy, McDowell Center, Oak Plains Academy

To be used for the purpose of aiding in assessing appropriateness for Residential Treatment;

The specific type of information (check below) is to be disclosed to/from:

_____

Name Street Address City State Zip

____ Progress Notes
____ Social History
____ Laboratory Data
____ X-ray Information
____ Alcohol and/or Drug
Use information (treatment records)

____ Discharge Summary
____ Psychological Testing
____ Physical Examination
____ Academic Information/IEP
____ Doctor's Orders
____ Psychiatric Testing/Evaluation
____ The following Information:

____ any other information_____

I understand that I may revoke this consent at any time by submitting a written declaration of revocation. I also understand that any information released prior to the legal guardian's revocation is legal and shall not constitute a breach of the legal guardian's rights to confidentiality. Unless I revoke this authorization prior to such time, this authorization to release information shall remain valid for one year. I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. This release also allows for referring facility to send referral documentation (to include information collected from other third party providers) to other facilities within the state of Tennessee and Atlanta, Georgia for the purpose of residential treatment. I understand and authorize these actions.

_____ _____/_____/_____
Patient Date

_____ _____/_____/_____
Parent/Guardian/Authorized Representative Date

_____ _____/_____/_____
Witness Date