KIDLINK TREATMENT SERVICES *Of Tennessee*

RELEASE OF INFORMATION

_____	_____	_____
Patient's Name	Birth date	Social Security Number
_____	_____	_____
Male/Female	Grade	School

SEND INFORMATION TO:

- ***Cedar Grove: Donnie Hitchcock, Director of Admissions***
  (o) 615-895-9590 ext. 104 (f) 615-895-9592
  Robert.Hitchcock@uhsinc.com
- ***Hermitage Hall: Richard Miller, Interim Director of Admissions***
  (o) 615-250-2360 (f) 615-250-2388
  Richard.Miller@uhsinc.com
- ***Mountain Youth Academy: Betty Villarreal, Director of Admissions and Susan Osborne, Admissions Coordinator***
  (o) 423-727-3230 (f) 423-727-9899
  Betty.Villarreal@uhsinc.com
  Susan.Osborne@uhsinc.com
- ***Natchez Trace Youth Academy: Jessica Harrison, Director of Admissions and Sabrina Wyatt, Admissions Coordinator***
  (o) 931-296-1183 ext. 1065 or ext. 1057 (f) 931-296-5414
  Jessica.Harrison@uhsinc.com
  Sabrina.Wyatt@uhsinc.com
- ***Oak Plains Academy: Tommy Cunningham, Director of Admissions and Erica Lewis, Admissions Coordinator***
  (o) 931-362-2008 ext. 208 (f) 931-362-2816
  OAKPLAINSACADEMYADMIT@UHSINC.COM

To be used for the purpose of aiding in assessing appropriateness for Residential Treatment within our network; OR for the purpose of _____.

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)
____ any other information_____

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

Initials _____ ***Expiration date(one yr from today):*** _____

_____ _____/_____/_____
Patient Date

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

_____ _____/_____/_____
Witness Date