



RELEASE OF INFORMATION

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

Information Disclosed To/From: KTS Call Center/Reviewing Facilities/Funding Entities for Authorization Purposes

SEND INFORMATION TO: KidLink Treatment Services
100 Health Park Drive, Building 3, Suite 300
Brentwood, TN 37027

OR
Confidential Referral FAX Number: 615-234-4979
E-mail: KTSTNReferral@uhsinc.com

Network Facilities to Review: all appropriate

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

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

- Name Street Address City State Zip
Progress Notes Discharge Summary
Social History Psychological Testing
Laboratory Data Physical Examination
X-ray Information Academic Information/IEP
Alcohol and/or Drug Doctor's Orders
Use information (treatment records) 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.

Initials Expiration date:

Patient Date

Parent/Guardian/Authorized Representative Date

Witness Date