

**Behavioral Health Associates**  
6216 Airpark Drive  
Chattanooga, Tennessee 37421  
Phone 423-899-0024  
Fax 423-899-5688

## Authorization to Release Information

When completed and signed by you, this form authorizes Behavioral Health Associates to release/ exchange protected health information from your clinical record with the person/facility designated below:

Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_

I, \_\_\_\_\_, authorize Behavioral Health Associates to release/

exchange the following information for \_\_\_\_\_

(Patient's name and Date of Birth)

**To** the facility/organization listed above  
 **From** the facility/organization listed above

Notification of Treatment at BHA  
 Coordination of Care Regarding Medication  
 Lab/Procedure Reports and Results  
 Progress Notes  
 Other Specific Information (use space below)

Psychiatric/Psychological Evaluation  
 Alcohol and/or Drug-Related Diagnosis and Treatment Notes  
 AIDS- and/or HIV-Related Diagnosis and Treatment Notes

I am requesting Behavioral Health Associates to release this information for the following reasons ("at the request of the individual" is all that is required if you do not desire to state a specific purpose):

\_\_\_\_\_  
\_\_\_\_\_

This authorization shall remain in effect until \_\_\_\_\_

You have the right to revoke this authorization, in writing, at any time by sending such written notification to Behavioral Health Associates. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization.

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

If this authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.