KIDLINK TREATMENT SERVICES

RELEASE OF INFORMATION

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

_____ _____
Male/Female Grade

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

SEND INFORMATION TO: **KidLink Treatment Services**
1000 Health Park Drive, Building 3, Suite 400
Brentwood, TN 37027

OR

Confidential Referral FAX Number: **866-775-4208 or 615-250-2387**

Network Facilities to Review: _____
_____
_____

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 by:

_____
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
_____ Doctor's Orders
_____ 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 release of information which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breech of my rights to confidentiality. Unless I revoke this authorization prior to such time, this authorization to release information shall remain valid.

_____ _____/_____/_____
Patient Date

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

_____ _____/_____/_____
Witness Date