WESTBROOK MEDICAL CENTER

7328 MIDDLEBROOK PIKE
KNOXVILLE, TN 37909
(865) 769-2600

CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

I _____ authorize Dr. Richard Poehlein or Dr. Clifford Davidson and members of
Name (print) heir staff at the above address to:

MD check all that apply

☐ Receive my medical history information from the following physicians:
(name, address)_____

(name, address)_____

☐ Receive my treatment records from the following therapist
Therapist (name, address)_____

☐ Release my treatment information/records to the following healthcare professional
(name, address)_____

This information is for the following purposes (any other use is prohibited): _____

_____

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken in reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

_____ _____
Patient Signature Date

_____ _____ _____
Witness Signature Witness Name (Print) Date