GME Policy – Fitness For Practice
(Attachment B)
Authorization to Release Information
of Mental Health Evaluation Drug/Alcohol Testing

I,_____(Name of Resident), whose Date of Birth is_____,

hereby authorize ☐ [UTHSC Health Services] ☐ [specify other:]_____
_____, to disclose to___The University of Tennessee, Graduate Medical Education and its administrators, including the GME Associate Dean and Director, as well as the Program Director, as well as_____ (Name of Person or Title of Person or Organization)

Description of Information to be Disclosed

☑ Assessment ☑ Diagnosis ☑ Psychosocial Evaluation ☑ Treatment Plan or Summary ☑ Drug/alcohol test results

☑ Current Treatment Update ☑ Presence/Participation in Treatment

☑ Collateral Interview for Evaluation ☑ Discharge Summary ☑ Continuing Care Plan

☑ Progress in Treatment ☑ Demographic Information

___ Psychotherapy Notes* (*Cannot be combined with any other disclosure)

___ Other_____ ___Other_____

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to UTHSC GME. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization. I further understand that if I revoke this Authorization that I will be subject to the discipline under GME Policy #__, Fitness for Practice.

Expiration
Unless sooner revoked the authorization expires six months from this date on:____N/A___Or as otherwise indicated:_____.

Form of Disclosure
The disclosure may be made in any manner appropriate and consistent with applicable law, including but not limited to, verbal, in paper format or electronically.

Redisclosure
I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

_____
Signature of Resident Date

____ Check here if Resident refuses to sign this Authorization

_____
Signature of Staff Witness Date