CASA
Court Appointed Special Advocates
FOR CHILDREN
NASHVILLE

601 Woodland Street
Nashville, TN 37206
615-425-2383 Fax 615-242-9873 www.casa-nashville.org

AUTHORIZATION FOR DISCLOSURE
Of Protected Health Information pursuant to 45 CFR 164.508(a)(1)

1. **I hereby authorize the disclosure of protected health information as described below from the record(s) pertaining to:**

   Patient Name:_____

   Birth Date:_____

   Social Security Number:_____

2. **Person(s) or class of persons authorized to disclose the protected health information:**

   This authorization pertains to the following health care provider who treated the patient named above or have medical and billing records of the patient named above or have medical and billing records of the patient named above:

   Provider Name:_____

3. **Persons(s) or class of persons to whom the protected health information may be disclosed:**

   The protected health information may be disclosed to at CASA, Inc. of Davidson County, 601 Woodland Street, Nashville, TN. 37206:

   _____ _____
   (Advocate) (Advocate Supervisor)

4. **Description of protected health information to be disclosed:**

   The protected health information to be disclosed includes the entire medical record above.

I am for the Child

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5. **HIV/AIDS:** I understand that the records used and disclosed pursuant to the authorization form may include test results and other information relating to Human Immunodeficiency Virus ("HIV") infection or Acquired Immunodeficiency Syndrome ("AIDS").

6. **Drug/Alcohol Treatment Records:** I understand that the records used and disclosed pursuant to this authorization form may include information relating to treatment and counseling for drug and/or alcohol dependency.

7. **Mental Health Records (other than "psychotherapy notes" as defined under HIPAA):** I understand that the records used and disclosed pursuant to this authorization form may include mental health records other than "psychotherapy notes" as that term is defined under HIPAA and its promulgating rules.

8. **Purpose of Disclosure:**

   The protected health information will be disclosed for the following purposes: To assist the Court Appointed Special Advocate (CASA Volunteer) in evaluation and investigation related to a Juvenile Court case in which CASA has been appointed to advocate for the best interest of a child.

9. **I understand that the protected health information described above may be re-disclosed and no longer protected by federal and state privacy regulations.**

10. **I understand that I may revoke this authorization in writing at any time. I understand that I may revoke this authorization by sending or faxing a written notice to the disclosing party in question identified in (2.) above. This written revocation must state my intent to revoke this authorization. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and any revocation will not affect those actions.**

11. **I understand that an entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization.**

12. **Any facsimile, copy or photocopy of this authorization shall be as valid as the original.**

13. **This authorization shall expire at the conclusion of CASA's court appointment as a child advocate for the child in question.**

Signature of Patient or Patient's Legal Representative:_____

Printed Name of Legal Representative (if any):_____

Date of Patient Signature (or Patient's Legal Representative:_____

Signature of CASA Representative:_____

Date of CASA Representative Signature:_____