**GME Policy #745 Attachment B Fitness For Practice Exam Authorization**  
 **to Release Information**

**Authorization to Release Information**

of Mental Health Evaluation Drug/Alcohol Testing

I, (Name of Resident), whose Date of Birth is ,

hereby authorize  [Erlanger Express Care]  [specify other:]

, to disclose to The University of Tennessee, Graduate Medical Education and its

administrators, including the Associate Dean/DIO, Director of GME, 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 the UT College of Medicine 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 UT GME Policy #745, 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 re-disclosed 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