

**State of Tennessee**  
**Department of Mental Health and Developmental Disabilities**  
**Division of Alcohol and Drug Abuse Services**

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**Tennessee Access to Recovery II**  
**Authorization for Release of Information**

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

**I authorize release of information by:**

**I authorize release of information to:**

\_\_\_\_\_  
(agency name)

State of Tennessee  
TDMHDD  
Division of Alcohol & Drug Abuse Services  
Fax number: 615-532-2419

**Purpose of this Request:** To authorize Tennessee Access to Recovery II services and evaluate their effectiveness.

**Types of Records Authorized:** Access to Recovery II Screening Information  
Access to Recovery II Assessment Information  
Access to Recovery II Monitoring Information  
Access to Recovery II Services Information  
Other \_\_\_\_\_

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I may revoke this consent at anytime except to the extent that the provider which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate 365 days after expiration of Tennessee Access to Recovery II voucher services.

Signature of  
Consumer \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

*Fax form to the Division of Alcohol & Drug Abuse Services (615) 253-6221*