Daybreak Treatment Center
2262 S. Germantown Rd.
Germantown, TN 38138
Phone: (901) 753-4300 Fax: (901) 751-8105

Authorization to Release Information

(Valid until revoked in writing by Parent/Legal Guardian or Patient-18 years or older)

Patient Name: ____ Date of Birth: ___/___/___

Address: ____

Initial all the options below to which you agree:

_____ If copies of any medical records may be needed in the future by a Parent/Legal Guardian/Patient (18 Years or Older), please provide the names of whom those records can be released:

____________________________________ ____________________________________

____________________________________ ____________________________________

_____ I give Daybreak and staff permission to obtain and release my records from any physician, mental healthcare provider, healthcare facility, school or individual that has assisted, or will assist in the future, with my case including, but not limited to, the following individuals, providers and agencies:

____________________________________ ____________________________________

____________________________________ ____________________________________

____________________________________ ____________________________________

____________________________________ ____________________________________

_____ I give Daybreak and staff permission for messages to be left on my answering machine or voice mail system, or with other family members.

______ I give Daybreak and staff permission for electronic communication including email and faxes.

I have written initials next to the options that I agree to.

_______________________________________ _____/_____/_____

Signature (Parent or Legal Guardian) Date
(Patient-18 Years or Older)