MHI Application

Applicant Supporter Release of Information

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Making the decision to go to residential mental health treatment can be scary and challenging, yet extremely rewarding. It's important to have someone close to you cheering you on and helping you navigate the experience. We ask that you identify 1 individual for Mental Health Initiative to speak to throughout the application process if needed that will be supportive of you during your program stay if MHI is able to award you a grant for treatment. Prior to naming this person, be sure to ask them and confirm they are able and willing to help you through this process. Without this form complete, we are unable to speak to your support person due to confidentiality.

**If you are unable to find an applicant support individual, please contact Mental Health Initiative for support before continuing at 615-212-9710.

Applicant Information

Patient First Name *

First Name

Patient Middle Name

Middle Name

Patient Last Name *

Last Name

Date of Birth *

Month

Day

Year

Applicant Supporter Information

First and Last Name *

First & Last Name

Email *

Email

Phone *

Phone Number

Information to be disclosed

I understand that US law requires your consent for the release of confidential information related to mental health or developmental disability. With this understanding, I hereby waive any right to confidentiality arising under US law and authorize the release of records of information, but only to the extent specified below.

☐ **Mental Health Initiative Application Status, Current Treatment Status, Treatment History, and any other information pertinent or relevant to supporting me in receiving assistance from Mental Health Initiative.**

I authorize the applicant supporter identified above to release or receive verbal and/or written information regarding my **Mental Health Initiative Application Status, Current Treatment Status, Treatment History, and any other information pertinent or relevant to supporting me in receiving assistance to and from:**

Mental Health Initiative

(615) 212-9710

director@mentalhealthinitiative.info

Nashville, TN 37209

This authorization shall remain in effect for 1 year from the date signed, at which time it shall expire and no further release of information shall be made under its terms. I understand that I can revoke this authorization at any time by giving written notice to the parties named above. I hereby release the parties named above from any liabilities for release of this information

Refusal to sign/right to revoke

I understand that signing this form is voluntary, and if I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation. The revocation will be effective immediately upon Mental Health Initiative's receipt of my written notice.

Authorization

Patient First Name *

First Name

Patient Last Name *

Last Name

Patient/Representative Signature *

Clear Undo

If Individual is unable to sign this Authorization, please complete the information below:

Name of Guardian

First Name

Last Name

Legal Relationship

Legal Relationship

Date

June 26 2023