Talbott Recovery Campus
5355 Hunter Road
Atlanta, Georgia 30349

Patient Label

AUTHORIZATION AND CONSENT TO RELEASE INFORMATION

Patient Name:_____ **Birth Date:**_____ **Last Four SSN:**_____

Phone:_____ **Email:**_____

I HEREBY AUTHORIZE TALBOTT RECOVERY: ☐ **TO RELEASE TO** ☐ **TO REQUEST FROM**

Name:_____ **Phone:**_____

Address:_____ **City:**_____ **State:**_____

Zip Code:_____ **Email:**_____ **FAX:**_____

THE FOLLOWING INFORMATION: (Check (Y) Yes OR (N) No on each individual line option)

☐Y ☐N Admission Face Sheet/Demographics	☐Y ☐N Drug Screens	☐Y ☐N Treatment Plan & Updates
☐Y ☐N Psychiatric Evaluation	☐Y ☐N Laboratory Reports	☐Y ☐N Continuing Care Plan
☐Y ☐N Psychological Evaluation	☐Y ☐N Physician Orders	☐Y ☐N 72 hr Assessment Report
☐Y ☐N Discharge Summary	☐Y ☐N Progress Notes for Insurance	☐Y ☐N Intake/Assessment Forms
☐Y ☐N History and Physical Exam	☐Y ☐N Problem & Diagnoses List	☐Y ☐N Consults
☐Y ☐N Treatment Update / Status – Verbal	☐Y ☐N Quarterly Monitor Rpt/Letter	☐Y ☐N Correspondence: Calls/Letters
☐Y ☐N Treatment Update / Status – Written	☐Y ☐N Medication List	☐Y ☐N Nursing Assessment
☐Y ☐N Financial Information	☐Y ☐N Other: _____	

Dates of Service: _____ **How would you like this information sent?** ☐ **Mail** ☐ **Fax** ☐ **Email** ☐ **Verbal**

Purpose: ☐Personal ☐Insurance ☐Legal ☐Treatment/Continuing Care ☐Disability/FMLA ☐Other (specify:)_____

I understand my health information is protected by federal regulations (Alcohol and Drug Abuse Patient Records, 42 CFR Part 2; and HIPAA, 45 CFR) and state privacy laws, and disclosure is allowed only with my authorization except in limited circumstances described in the Talbott Privacy Notice.

I understand that authorizing the use or disclosure of the health information identified above is voluntary and I need not sign this authorization form to ensure healthcare treatment, unless I am receiving care solely to create protected health information for disclosure to a third party [42 CFR § 164.508(b)(4)(iii)].

Federal confidentiality regulations (42 CFR Part 2) prohibit re-disclosure of information from alcohol and drug abuse patient records. However, I understand that any disclosure of private health information carries the potential for unauthorized re-disclosure and may no longer be protected by federal privacy laws or regulations. I further agree to indemnify and hold harmless Talbott staff from all liability that may arise from the release of the information herein requested. I understand that communications resulting from this release will reveal that I received services at Talbott.

I understand that I have the right to inspect or obtain a copy of the health information to be disclosed. Medical records frequently contain information which may be privileged and/or confidential remarks furnished by the patient, patient's family and staff. If, in the judgment of the medical staff, disclosure of the privileged/confidential information will be harmful to the patient, release of such information may be withheld in accordance with specific state and federal regulations. Records released may contain alcohol and drug treatment information, patient photographs, AIDS/HIV or psychiatric/psychological/other mental health privileged or confidential information. Certain communications are privileged and not subject to release without patient consent under state and/or federal law. After giving due consideration to the above statement, I authorize Talbott and/or members of its staff to furnish information, including electronic, photo static or faxed copies of my medical record, including matters privileged under the laws of the state of Georgia, and applicable Federal laws and regulations including but not limited to 42 CFR Part 2, and the Health Insurance Portability And Accountability Act (HIPAA), to the above organization/individual, or to its agents.

I understand that I have the right to revoke this authorization at any time. I understand the revocation will not apply to information that has previously been released in response to this authorization. Unless otherwise revoked this authorization is only valid for a period of one (1) year from the date of my signature, unless I specify another date or event here: _____.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date