

AUTHORIZATION AND CONSENT TO RELEASE INFORMATION

Talbott Recovery Campus • 5448 Yorktowne Drive • Atlanta, GA 30349 • Phone (770) 994-0185 • Fax (770) 994-2024

Patient Name: _____ Birthdate: _____ MR: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ SS #: _____ -- _____ -- _____ All Specific Dates: _____

Name/Organization: _____ Phone: _____

Street Address: _____ City: _____ State: _____ Zip: _____

I AUTHORIZE TALBOTT RECOVERY CAMPUS TO RELEASE TO AND RECEIVE FROM
THE ABOVE PERSON/AGENCY THE FOLLOWING INFORMATION: (Check (Y) yes or Check (N) no)

- | | | |
|---|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Admission Face Sheet | <input type="checkbox"/> Y <input type="checkbox"/> N Treatment Plan & Reviews | <input type="checkbox"/> Y <input type="checkbox"/> N History and Physical Exam |
| <input type="checkbox"/> Y <input type="checkbox"/> N Patient Identification Number | <input type="checkbox"/> Y <input type="checkbox"/> N X-ray Reports | <input type="checkbox"/> Y <input type="checkbox"/> N Continuing Care Plan |
| <input type="checkbox"/> Y <input type="checkbox"/> N Family Assessment | <input type="checkbox"/> Y <input type="checkbox"/> N Psychological Evaluation | <input type="checkbox"/> Y <input type="checkbox"/> N Laboratory Reports |
| <input type="checkbox"/> Y <input type="checkbox"/> N Family Information Packet | <input type="checkbox"/> Y <input type="checkbox"/> N Assessment Report | <input type="checkbox"/> Y <input type="checkbox"/> N Drug Screens |
| <input type="checkbox"/> Y <input type="checkbox"/> N Impact Letter(s) | <input type="checkbox"/> Y <input type="checkbox"/> N Progress Notes | <input type="checkbox"/> Y <input type="checkbox"/> N Physician Orders |
| <input type="checkbox"/> Y <input type="checkbox"/> N Financial Information | <input type="checkbox"/> Y <input type="checkbox"/> N Problem & Diagnoses List | <input type="checkbox"/> Y <input type="checkbox"/> N Biopsychosocial Questionnaire |
| <input type="checkbox"/> Y <input type="checkbox"/> N Treatment Update / Status – Verbal | <input type="checkbox"/> Y <input type="checkbox"/> N Nursing Assessment | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Consult/Evaluation |
| <input type="checkbox"/> Y <input type="checkbox"/> N Treatment Update / Status – Written | <input type="checkbox"/> Y <input type="checkbox"/> N Quarterly Monitoring Report | <input type="checkbox"/> Y <input type="checkbox"/> N Discharge Summary |
| <input type="checkbox"/> Y <input type="checkbox"/> N Correspondence: Phone Calls & Letters | <input type="checkbox"/> Y <input type="checkbox"/> N Medication List | <input type="checkbox"/> Y <input type="checkbox"/> N Consent Forms |
| <input type="checkbox"/> Y <input type="checkbox"/> N Correspondence (Specify): _____ | | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Other: (Specify): _____ | | |

FOR THE PURPOSE OF: _____

Medical records frequently contain confidential remarks furnished by the patient, patient's family and staff. If, in the judgment of the medical staff, disclosure of such information will be harmful to the patient, release of such information will be withheld.

I understand that information received or medical records prepared after this release form is completed, regarding my condition and the services I have received in the course of my diagnosis and treatment, may be subject to release to authorized parties in compliance with federal and state law and the terms of this form. **I understand that the records released may contain alcohol and drug treatment, AIDS/HIV or psychiatric/psychological/psychosexual information. I understand this communication will reveal my presence as a patient in a treatment facility.**

This release demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 & 164 and Federal Regulations 42 CFR Part 2 and all federal regulations and interpretive guidelines promulgated thereunder. **The recipient of this information may not disclose this information unless another authorization is obtained from me or unless such disclosure is required or permitted by law (42 CFR Part 2).** I understand once the requested information is disclosed, the HIPAA Privacy Regulations may no longer protect it should the recipient redisclose it.

I authorize the above named person/organization and/or members of their staff, to furnish the above information, including photostatic or faxed copies of my medical records to the above named organization or to its agents. I further agree to hold harmless Talbott Recovery Campus and its staff and agents from all legal liability that may arise from the release of information herein requested.

I understand that I may revoke this consent to release information in writing at any time, except to the extent that action has been taken in reliance thereon. In any event, upon fulfillment of the above-stated purpose, this consent will automatically expire one year from the date signed. I further understand that Talbott Recovery Campus reserves the right to notify the above-named person, corporation or agency of my revocation in the event that I revoke this consent to release information.

PATIENT SIGNATURE

DATE

WITNESS SIGNATURE

DATE