



Talbott Recovery Campus  
 5335 Hunter Road  
 Atlanta, GA 30349  
 Medical Records Fax: 404-765-9088



**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

Patient Name: \_\_\_\_\_ Maiden/Prior Name: \_\_\_\_\_

Admission Date: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Current Phone #: \_\_\_\_\_

Current Address: \_\_\_\_\_

**I am requesting disclosure of my protected health information for the following purpose:**

- Continuing Care
- Disability Determination
- Child Custody
- Academic
- Legal Investigation
- Other: \_\_\_\_\_

**I authorize the release of the following:**

- Comprehensive Assessment (Intake, Nursing, Psychosocial, Psychiatric and Education Assessments)
- History and Physical
- Discharge Summary
- Alcohol and Drug Abuse Treatment Records
- Discharge Instructions, Discharge/Continuing Care Plan
- Physician's Orders
- Treatment Progress
- Psychological Evaluation
- Lab/Diagnostic Reports
- Progress Notes
- HIV Test Results and AIDS Treatment Records
- Insurance/Payment
- Mental Health Records
- Other: \_\_\_\_\_

Emergency Contact:

To be released to:  \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
 Facility/Business/Name Relationship Telephone Number

\_\_\_\_\_ @ \_\_\_\_\_ .com \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
 Email Address City State Zip Code Fax Number

To be released by:  Talbott Recovery Campus \_\_\_\_\_ Provider (678) 251-3100  
 Facility/ Business/Name Relationship Telephone  
 5335 Hunter Road Atlanta GA 30349 (404)765-9088  
 Address City State Zip Code Fax Number

(If not indicated, authorization will expire one year from signature date, or when revoked) **This authorization will expire on \_\_\_\_/\_\_\_\_/20\_\_\_\_.**

You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by federal regulations. You have a right to inspect and receive a copy of the information that is to be disclosed. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with the copying of my information in the processing of this request.

**This form must be completed in full before signing:**

\_\_\_\_\_  
 Patient's Signature (required for ages 12 and older) Parent/Legal Guardian Signature (if applicable) Relationship to Patient

\_\_\_\_\_  
 Staff Signature Date Signed  Entered in Tier

This authorization is intended to allow **Talbott Recovery Campus** to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) or the STATE MENTAL HEALTH ACT is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure. **Talbott Recovery Campus** is not liable for such re-disclosures.

<b>This section to be completed if revoked:</b>		
_____ Patient's Signature (required for ages 12+)	_____ Parent/Legal Guardian Signature (if applicable)	_____ Relationship to Patient
_____ Staff Signature	_____ Date Signed/Revoked	<input type="checkbox"/> Revoked