To prevent delay in processing your request, please include a copy of a government issued photo ID (i.e. a driver's license) for verification of signature.

TALBOTT RECOVERY

Talbott Recovery Campus
5335 Hunter Road
Atlanta, GA 30349

**This BH Facility is closed as of 11/2026**

**Custodian of Records for closed facilities:**
**Universal Health Services-Nashville Regional Office**
**Phone: 615-312-5834**
**Fax: 615-997-1200**
**Email: nrorecordsrequests@uhsinc.com**

# 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 ☐ Child Custody ☐ Legal Investigation
☐ Disability Determination ☐ Academic ☐ 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 _____ ___,_____
Facility/ Business/Name Relationship Telephone

5335 Hunter Road Atlanta GA 30349 ___,_____
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

_____ _____
**Witness Signature** Date Signed

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.

**This section to be completed if revoked:**

_____ _____ _____
Patient's Signature (required for ages 12+ Parent/Legal Guardian Signature (if applicable) Relationship to Patient

_____ _____ ☐ Revoked
Staff Signature Date Signed/Revoked