

ACCEPTANCE

RECOVERY ▶▶▶

GIVE RECOVERY A VOICE

Authorization for Release of Confidential Information

Name: _____ Date of birth: _____ Last 4 of social: _____	I hereby authorize: Acceptance Recovery Center P.O. Box 6693 Athens, GA 30604
Purpose(s) for the Use <i>and/or</i> Disclosure of Protected Health Information is (please check all that apply): <input type="checkbox"/> Continuity of Care <input type="checkbox"/> Legal Request <input type="checkbox"/> Family <input type="checkbox"/> Employment <input type="checkbox"/> ALL OF THE ABOVE <input type="checkbox"/> Other: _____	To provide to and to receive from: <input type="checkbox"/> Facility: _____ or <input type="checkbox"/> Individual: _____ Relationship _____ Phone _____ Address _____ City/State/Zip _____ <input type="checkbox"/> Check if this person is an Emergency Contact

Information to be disclosed includes (check all information to be released)

<input type="checkbox"/> Recovery Planning <input type="checkbox"/> Complete Clinical Records <input type="checkbox"/> Progress Notes <input type="checkbox"/> Medication(s) <input type="checkbox"/> Successful Discharge <input type="checkbox"/> Unsuccessful Discharge	<input type="checkbox"/> Discharge Summary <input type="checkbox"/> Financial <input type="checkbox"/> Psychosocial/Assessment(s) <input type="checkbox"/> Psychiatric Evaluation (BHA) <input type="checkbox"/> Medical/Mental Diagnosis <input type="checkbox"/> Physicians Orders	<input type="checkbox"/> Medical Emergency <input type="checkbox"/> ALL OF THE ABOVE <input type="checkbox"/> Other _____ <input type="checkbox"/> Specify: _____ _____ _____
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This release will remain in effect for the duration of program participation and 6 months post-discharge unless otherwise rescinded.

Client Signature

Date

Staff Signature

Date

To Rescind: I hereby rescind this consent to release information regarding my care as provided in this Authorization.

Client Signature

Date

THE HIPAA PRIVACY RULES REQUIRE COVERED ENTITIES TO SAFEGUARD PROTECTED HEALTH INFORMATION (PHI) RELATED TO A PERSON'S HEALTH CARE. INFORMATION BEING SENT TO YOU MAY INCLUDE PHI, AFTER APPROPRIATE CONSENT, ACKNOWLEDGEMENT, OR AUTHORIZATION FROM THE PATIENT OR UNDER CIRCUMSTANCES THAT DO REQUIRE PATIENT AUTHORIZATION. YOU, THE RECIPIENT, ARE OBLIGATED TO MAINTAIN PHI IN A SAFE AND SECURE MANNER. YOU MAY NOT RE-DISCLOSE THIS PATIENT INFORMATION WITHOUT ADDITIONAL PATIENT CONSENT OR AS REQUIRED BY LAW. UNAUTHORIZED RE-DISCLOSURE OR FAILURE TO SAFEGUARD PHI COULD SUBJECT US, OR YOU, TO PENALTIES DESCRIBED IN FEDERAL (HIPAA) AND STATE LAW. IF YOU, THE READER OF THIS MESSAGE, ARE NOT THE INTENDED RECIPIENT, OR THE EMPLOYEE OR AGENT RESPONSIBLE TO DELIVER IT TO THE INTENDED RECIPIENT, OR THE EMPLOYEE OR AGENT RESPONSIBLE TO DELIVER IT TO THE INTENDED RECIPIENT, PLEASE NOTIFY ARC IMMEDIATELY AND DESTROY THE RELATED MESSAGE. THANK YOU.

04/29/24- MMc
Acceptance Recovery Center