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 *and/or* Disclosure of Protected Health Information is (please check all that apply): ☐ Continuity of Care ☐ Legal Request ☐ Family ☐ Employment ☐ ALL OF THE ABOVE ☐ Other:_____	To provide to and to receive from: ☐ Facility: _____ or ☐ Individual: _____ **Relationship**_____ **Phone**_____ **Address**_____ **City/State/Zip**_____ ☐ **Check if this person is an Emergency Contact**

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

☐ Recovery Planning	☐ Discharge Summary	☐ Medical Emergency
☐ Complete Clinical Records	☐ Financial	☐ ALL OF THE ABOVE
☐ Progress Notes	☐ Psychosocial/Assessment(s)	☐ Other _____
☐ Medication(s)	☐ Psychiatric Evaluation (BHA)	☐ Specify:_____
☐ Successful Discharge	☐ Medical/Mental Diagnosis	_____
☐ Unsuccessful Discharge	☐ Physicians Orders	_____

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release will remain in effect for the duration of program participation and 6 months post-discharge unless otherwise rescinded.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**