Turning Point Hospital

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Moultrie, GA 31768

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800-342-1075 (USA)
Fax: (229) 891-2198

AUTHORIZATION FOR RELEASE OF INFORMATION

Date _____ Patient Name _____ MR# _____

I hereby freely authorize _____ to release to:

_____

_____

_____

above 3 lines; full name and address of person or agency receiving information

the following information checked below from my records of _____

DATE OF ADMISSION

_____

I realize that these records can or will be related to alcohol/drug use or treatment and contain psychiatric information. Information requested MUST be specific.

_____ face sheet	_____ psychiatric testing	_____ psychological evaluation (MMPI)
_____ discharge summary	_____ lab/x-ray/other tests	_____ verbal information/patient progress
_____ H&P	_____ medication records	_____ HIV testing
_____ progress notes	_____ treatment plan	_____ school records
_____ physician orders	_____ aftercare plan	_____ family intake

_____ other: (specify) _____

_____

The purpose or need for disclosure is: (NOT VALID IF NOT COMPLETED)

_____ legal matters	_____ keep Probation/Parole Officer informed
_____ comply with court order	_____ settlement of insurance claim
_____ obtain records to aid in treatment	_____ keep family informed/involved in treatment
_____ follow-up care or discharge planning	_____ keep EAP/referral source informed
_____ keep school auhtorities informed	_____ payment of bill

_____ other: (specify) _____

_____ Send family program packet and questionnaire

This authorization may be revoked by me in writing any time before the release of the above information. This authorization will expire in one year from date signed unless another date is specified here _____, or upon payment of the bill (for insurance purposes only). This release is limited to the person or organization named above and further release is prohibited without specific additional written consent of the patient.

This Release of Information demonstrated complaince 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 regulation and interpretive guidelines promuglated thereunder.

Once the requested PHI is disclosed, the Privacy regulations may no longer protect it if the PHI'd receipient rediscloses it.

Patient Signature _____ Date _____

_____ Date _____

Parent or guardian if patient is under 18 or under guardianship

_____ Date _____

Witness

A Hospital Dedicated to the Treatment of Alcoholism and Drug Abuse