CONSENT FOR RELEASE OF MEDICAL INFORMATION
HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act,
45 C.F.R. Parts 160 and 164)**

Patient name: _____ Social Security Number: _____

Address: _____

Phone Number: _____ Treatment dates from: _____ to _____ Date of Birth _____

I authorize: (enter your current physician's information)

_____

_____

_____

To release copies of my medical records to:

Adult & Teen Challenge of the Greater South
Arkansas Kansas Mississippi Missouri Tennessee

Adult & Teen Challenge of the Greater South (and its representatives)
700 East Parkway Drive
Russellville, AR 72801
866-567-7101 **Phone/** 866-477-4089 **Fax**
Email corporateintake@atcgs.org

I authorize release of information of the following portions of my medical record: (circle all that apply).

All Mental Health Substance Abuse Communicable Disease Pregnancy

Only the following: _____

I understand that this information shall be in effect for the dates written above, following the date of signature. However, I understand that this authorization may be revoked at any time by giving oral or written notice to the medical office. A photocopy of this authorization shall constitute a valid authorization. I understand that once my medical records have been released, the medical office cannot retrieve them and has no control over the use of the already released copies.

I hereby release the requesting organization and its representatives from any and all liability that may arise as a result of my authorized release of records.

Should my case require review by a governing agency or another medical profession actively involved in my care to make a final determination, it is with my consent that a copy of these records will be submitted to the agency or medical profession for this review.

_____ _____
Patient (or legal representative) Date:

_____ _____
Relationship to Patient: Witness:

NOTICE: The information has been disclosed to you from records whose confidentiality has been protected by federal and state law. You are prohibited from making further disclosures of such information without specific consent of the persons to whom such information pertains or as otherwise permitted by state law. A general authorization is not sufficient for this purpose.