



Carter Hope Center Recovery Residence

506 East Hawthorne Street Dalton, GA 30721
Office 706 226-7044 Fax 706 226-6216

CONSENT FOR THE RELEASE OF CONFIDENTIAL ALCOHOL OR DRUG TREATMENT INFORMATION

I, _____, authorize
(Name of patient)

Carter Hope Center Recovery Residence
(Name or general designation of program making disclosure)

to disclose to _____ the
(Name of person or organization to which disclosure is to be made)

following information: Admission, Progress, Drug Screens, Lab results, Discharge Date, Reason for D/C and Discharge plan.
(Nature of the information)

The purpose of the disclosure authorized herein is to: Coordination of Services
(Purpose of disclosure)

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

Until _____
Date

For one year

Time necessary to complete treatment

Date

Signature of patient

Witness (relationship)

Signature of parent, guardian