



Black Bear Treatment Center, LLC
310 Black Bear Ridge
Santee, GA 30571



AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: [Redacted] Maiden/Prior Name: [Redacted]

Admission Date: [Redacted] Birth Date: [Redacted] Current Phone #: [Redacted]

Current Address: [Redacted]

I am requesting disclosure of my protected health information for the following purpose:

- Continuing Care, Disability Determination, Child Custody, Academic, Legal Investigation, Other

I authorize the release of the following:

- Comprehensive Assessment, History and Physical, Discharge Summary, Alcohol and Drug Abuse Treatment Records, Discharge Instructions, Physician's Orders, Treatment Progress, Psychological Evaluation, Lab/Diagnostic Reports, Progress Notes, HIV Test Results, Insurance/Payment, Other

Emergency Contact: [Redacted]

To be released to: [Redacted] Facility/Business/Name, Relationship, Telephone Number, [Redacted] @ [Redacted].com, Address, City, State, Zip Code, Fax Number

To be released by: [X] Black Bear Treatment Center, LLC d/b/a Black Bear Lodge, Provider (470)539-6905, Facility/ Business/Name, Relationship, Telephone, 310 Black Bear Ridge, Santee Nacoochee, GA, 30523, (706)348-6144, Address, City, State, Zip Code, Fax Number

(If not indicated, authorization will expire one year from signature date, or when revoked) This authorization will expire on [Redacted] / [Redacted] / 20[Redacted].

You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization.

This form must be completed in full before signing:

Patient's Signature (required for ages 12 and older), Parent/Legal Guardian Signature (if applicable), Relationship to Patient, Staff Signature, Date Signed, Entered in Tier

This authorization is intended to allow Black Bear Treatment Center, LLC to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance 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 regulations and interpretive guidelines promulgated there under.

This section to be completed if revoked: Patient's Signature (required for ages 12+), Parent/Legal Guardian Signature (if applicable), Relationship to Patient, Staff Signature, Date Signed/Revoked, Revoked