RELEASE OF CONFIDENTIAL INFORMATION

I, the undersigned, hereby authorize the Directors, Counseling Staff, Nursing Staff, and/or Administrative Staff of the Addiction Treatment Program and the Health Information Management Department of South Miami Hospital to obtain from and disclose to persons named below, in a confidential and professional manner, the information indicated:

Name	Address	Circle Code Below	Initial Below
Relationship or Agency	(_____)_____ Phone	1,2,3,4,5	_____
Name	Address		
Relationship or Agency	(_____)_____ Phone	1,2,3,4,5	_____

INFORMATION CODE:

1. My patient status and general report of progress in treatment.
2. My continuing treatment plan and course of progress after discharge
3. Medical record information.
4. Historical, behavioral, legal, medical and family background information.
5. Insurance, Medicare, Medicaid, or other third-party payor information.

THIS DISCLOSURE IS MADE FOR THE PURPOSE OF:

- assisting the Addiction Treatment Program in evaluating or treating me;
- and/or cooperating with referral source, or employer;
- and/or, conducting family sessions;
- and/or, furnishing required information to appropriate authorities named above;
- and/or, facilitating Continuing Treatment and reporting Continuing Treatment attendance.

I hereby request and authorize South Miami Hospital, Addiction Treatment Program, to release and/or disclose any and all information relating to drug and/or alcohol diagnosis and treatment to all insurance companies, their review agencies, and any other entity or entities who do or may provide hospital, medical payment, or physician services coverage to the undersigned, including those entities listed by me at the time of my admission. I also authorize South Miami Hospital to release my medical record to any agencies, attorneys, or other third parties that the hospital or any of the physicians rendering service to me deem necessary to collect any outstanding amount due them.

I understand that I may revoke this consent in writing to the Director of Addiction Treatment Program at any time except to the extent that action has already been taken in reliance thereon. I also understand that unless this consent is revoked by me it will expire, without express revocation, one (1) year from date of signature.

I consent to have one (1) Polaroid photograph of me taken for purpose of therapeutic intervention.

I consent to receive any phone call or visitor, as approved by the staff, with the following exceptions:

☐ Exceptions:_____

☐ No Exceptions. ☐ No Calls or Visitors.

_____

CONFIRMATION (Initial & Date)

Patient Signature:_____ Print Name:_____ Date/Time:_____

witness Signature: _____ Print Name:_____ Date/Time:_____

SOUTH MIAMI HOSPITAL

ADDICTION TREATMENT PROGRAM
RELEASE OF CONFIDENTIAL INFORMATION

Designation: White - Chart
Canary - ATP Patient
Pink - Continuing Treatment

SMH 1775 Rev. 12/11
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