Never Alone Recovery
Knoxville, TN

Authorization for Release of Information

Name: _____ DOB: _____

I hereby authorize: **NEVER ALONE RECOVERY** to release information to or receive information from:

Name of Person or Agency Holding Information:

_____

Address: _____

Phone: _____ Email: _____

The following type(s) of information from my records (and any specific portion thereof):

_____A&D Treatment Records; Medical History; Mental Health Information

_____Laboratory Reports, Physical Exams/Reports

_____Notification of admission and discharge; discharge summary

_____Verbal exchange of information; weekly updates, progress reports

_____Correspondence of information including letters, emails, reports

_____Emergency contact information; other personal information

_____Other(specific):_____

This consent of information is given freely, voluntarily, and without coercion. I understand the records released may contain alcohol and drug treatment information or psychiatric/psychological information. I understand this communication will reveal my participation in the transitional sober living program with Never Alone Recovery. I understand I may revoke this consent to release/receive information at any time upon my written request. In any event, upon fulfillment of this release, this consent will automatically expire 1 year from the signed date.

NOTICE TO THE PERSON/AGENCY RECEIVING INFORMATION: This information is being released to you from our records where federal law (CFC 42-part 2) protects confidentially. Federal Regulations prohibit you from making any further disclosure of this information without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization of release of medical or other information is NOT sufficient for this purpose.

_____ _____

Resident Signature Date

_____ _____

Staff Signature Date

Never Alone Recovery/ Phone: 615-568-8350/ Email- neveralonetransitional@gmail.com