<u>AUTHORIZATION FOR RELEASE OF INFORMATION</u>

PROJECT RESCUE RECOVERY PROGRAM
P.O. Box 1271
Hartselle, AL., 35640

Resident / Participant's Name ____

Date of Birth ____

Social Security Number____

Resident / Participant's Address____

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form.

I understand that this authorization will include disclosure of information relating to my addiction recovery care. My attitude and my conduct during the course of this program may also be disclosed as well as my health and general state of mind.

I have the right to revoke this authorization at any time by addressing the Facility Manger in writing. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. Terminating this authorization may result in my removal from the recovery center.

I understand that signing this authorization is voluntary.

Name and address of entity to release this information:

PROJECT RESCUE RECOVERY PROGRAM,
P.O. Box 1271
Hartselle, AL., 35640

Name and address of person(s) to whom this information will be released:

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Signature Authorization: ____

My questions about this form have been answered and I have been provided a copy of this form as requested.

Name of program member or authorized representative: __________________________

Date: ______________________________

PRRP Form 002