GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Name of Individual/Consumer/Patient/Applicant

Date of Birth

IF AVAILABLE:

ID Number Used by Requesting Agency

ID Number Used by Releasing Agency

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby request and authorize: _____

(Name of Person or Agency Requesting Information)

_____

(Address)

to obtain from: _____

(Name of Person or Agency Holding the Information)

_____

(Address)

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

_____

_____

for the purpose of: _____

_____

I understand that the federal Privacy Rule ("HIPAA") does not protect the privacy of information if re-disclosed, and therefore request that all information obtained from this person or agency be held strictly confidential and not be further released by the recipient. I further understand that my eligibility for benefits, treatment or payment is not conditioned upon my provision of this authorization. I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and understand that my authorization will remain in effect for: (PLEASE CHECK ONE)

☐ ninety (90) days unless I specify an earlier expiration date here: _____ (Date)

☐ one (1) year.

☐ the period necessary to complete all transactions on matters related to services provided to me.

I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken based upon it, I may withdraw this authorization at any time.

(Date) _____ (Signature of Individual/Consumer/Patient/Applicant)

(Signature of Witness) (Title or Relationship to Individual) _____ (Signature of Parent or other legally Authorized Representative, where applicable) (Date)

USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN

(Date this authorization is revoked by Individual) _____ (Signature of Individual or legally authorized Representative)