Georgia Department of Behavioral Health & Developmental Disabilities

Name of Individual/Consumer/Patient/Applicant

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize:

(Name of Person or Agency to whom information should be given - requesting agency)

(Address)

to obtain from:

(Name of health care provider holding the information - releasing agency)

(Address)

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

____ Initials I authorize the disclosure of alcohol or drug abuse information, if any.

____ Initials I authorize the disclosure of information, if any, concerning testing for HIV (human immunodeficiency virus) and/or treatment for HIV or AIDS (acquired immune deficiency syndrome) and any related conditions.

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 the Department or my healthcare provider will not condition my treatment, payment, or eligibility for any applicable benefits on whether I provide authorization for the requested release of information. I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and state law, and understand that my authorization will remain in effect for: (PLEASE CHECK ONE)

☐ 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 by sending written notice of my withdrawal of this authorization to the staff of the healthcare provider who is providing services to me, OR to the Department's Privacy Officer at 2 Peachtree St. NW, Atlanta, GA 30303-3142.

(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USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN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)