Georgia Department of Behavioral Health & Developmental Disabilities

D·B·H·D·D

Name of Individual/Consumer/Patient/Applicant

Date of Birth AND/OR Social Security Number

AUTHORIZATION FOR RELEASE OF INFORMATION – STANDARD REQUEST

I hereby authorize the disclosure of records/information

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

_____
(Address) (Phone/Fax)

To: DBHDD Community Forensic Services--
(Name of Person or Agency to whom information should be given - requesting agency)

_____
(Address) (Phone/Fax)

_____ Initials

I authorize the following information from my records (and any specific portion thereof):

Mental Health Treatment Records, including: ☐evaluations ☐progress notes ☐ medications ☐ discharge summaries

General Medical Records, including: ☐ evaluations ☐ progress notes ☐ discharge summaries ☐substance abuse treatment and testing

School Records, including: ☐ IEPs ☐ evaluations ☐ attendance records ☐ disciplinary records ☐ grade reports

_____ Initials

I authorize the disclosure of alcohol or drug abuse information, if any. (Please see paragraph 2 below). If I am a minor, my parent/guardian/court-ordered custodian and **BOTH** must initial here in order for this information to be released.

_____ Initials

_____ 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 condition

The above disclosure of information is for the purpose of: Court-ordered evaluation and/or treatment

1. *I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws (except as set forth in paragraph 2 below).*
2. *I understand that, pursuant to 42 C.F.R Part 2, alcohol and drug abuse records that I authorize to be disclosed pursuant to this document may not be further re-disclosed without my written consent, except by a court order that complies with the preconditions set forth at 42 C.F.R. 2.61 et seq., or the other limited circumstances specifically permitted by 42 C.F.R. Part 2. Any individual that makes such a disclosure in violation of these provisions may be reported to the United States Attorney and be subject to criminal penalties.*
3. *I understand that DBHDD 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.*
4. *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 OR ☐ until I am discharged from all DBHDD services.

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 revoke this authorization at any time as shown in the space below.

Signature of Individual/Consumer/Patient/Applicant	**Print Name**	**Date**	**Time am/pm**

OR Signature of other person authorized to sign for Individual (check one):	**Print Name**	**Date**	**Time am/pm**

☐ Parent of Minor ☐ Guardian ☐ Court-appointed Custodian of Minor ☐ Agent designated by Individual's advance directive

USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN

I hereby revoke this authorization and will send written notice of my withdrawal of this authorization to the staff of the healthcare provider who is providing services to me, OR to DBHDD's Privacy Officer at HIPAA@DBHDD.ga.gov or 200 Piedmont Avenue, S.E., West Tower, Atlanta, GA 30334.

Signature of Individual or Legally Authorized Person	**Date**	**Time am/pm**

If you have any concerns about your record request and the use of this form, you may also contact **DBHDD's Privacy Officer** at **HIPAA@DBHDD.ga.gov,** or by or by phone at **(404) 272-7123.**

D·B·H·D·D

NOTICE OF NONDISCRIMINATION:

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) complies with applicable federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex. DBHDD does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. To communicate effectively with us, DBHDD provides to people with disabilities free aids and services such as interpreters, and written information in other formats (large print, audio, accessible electronic formats). To communicate effectively with us, DBHDD provides to people whose primary language is not English free language services such as: interpreters and information written in other languages. If you need these services, contact Constituent Services at (404) 657-5964.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (404.657.5964)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (404.657.5964).
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (404.657.5964) 번으로 전화해 주십시오.
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (404.657.5964).
સયુ ના: જો તમે ગજુ રાતી બોલતા હો, તો મન:શલુ ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો (404.657.5964).
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (404.657.5964).
ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ (404.657.5964).
ध्यान द:ें यदद आप ह ंदी बोलते ह तो आपके ललए मु म भाषा सहायता सेवाएं उपल ह ।ै ें (404.657.5964).
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (404.657.5964).
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (404.657.5964).
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (404)657-5964
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para (404.657.5964).
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیالت زبانی بصورت رایگان برای شما فراهم می باشد. با (404) 657-5964
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (404.657.5964)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。(404.657.5964) まで、お電話にてご連絡ください。