Georgia Department of Behavioral Health & Developmental Disabilities

DBHDD

Name of Individual/Consumer/Patient/Applicant

Social Security Number AND/OR Date of Birth

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the disclosure of records/information

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

_____
(Address) (Phone/Fax)

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

_____
(Address) (Phone/Fax)

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

____ I authorize the disclosure of alcohol or drug abuse information, if any. (Please see paragraph 2 below)
Initials

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

The above information is for the purpose of: _____

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

Date **Signature of Individual/Consumer/Patient/Applicant**

Signature of Witness (Title or Relationship to Individual) **Signature of (check one):** **Date**

☐**Parent** ☐**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 the Department's Privacy Officer at 2 Peachtree St. NW, Suite 22.240 Atlanta, GA 30303-3142.

Date this authorization is revoked by Individual **Signature of Individual or legally authorized Representative**