**Georgia Department of Behavioral Health & Developmental Disabilities**

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: _____
(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). If I am a minor,
Initials my parent/guardian/court-ordered custodian and I **BOTH** must initial here in order for this information to be released.
____
Initials

____ I authorize the disclosure of information, if any, concerning testing for HIV (Human Immunodeficiency Virus)
Initials and/or treatment for HIV or AIDS (Acquired Immune Deficiency Syndrome) and any related conditions.

The above disclosure of 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 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 ☐ 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.*

| **Signature of Individual/Consumer/Patient/Applicant** | **Print Name** | **Date** |
|---|---|---|
| **OR Signature of other person authorized to sign for Individual (check one):** ☐ **Parent** ☐ **Guardian** ☐ **Court-appointed Custodian of Minor** ☐ **Agent designated by Individual's advance directive** | **Print Name** | **Date** |

**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 2 Peachtree St. NW, Suite 22.250 Atlanta, GA 30303-3142.*

**Date this authorization is revoked** | **Signature of Individual or Legally Authorized Representative**

**Complaints and Additional Information:** All complaints may be made to DBHDD and to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint in writing with your DBHDD facility or program, or with your treatment provider or services provider under contract or agreement with DBHDD's Office of Constituent Services which maintains your protected health information at telephone **(888) 785-6954**, fax number **(770) 408-5439**, by mail to **2 Peachtree Street, NW, Suite 24-473 Atlanta, Georgia 30303**, or email http://dbhdd.georgia.gov/office-constituent-services. You must state the basis for your complaint. Neither the facility, the provider, nor DBHDD will retaliate against you for filing a complaint. You may also obtain additional information about privacy practices from this contact person.

You may also contact **DBHDD's Privacy Officer by telephone at (404) 657-2282, fax number (404) 657-2173, or by mail to 2 Peachtree Street NW, Room 22.250, Atlanta Georgia, 30303-3142,** for further information about the complaint process or about this notice.

Signature of Individual or Legally Authorized Person | Date

***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. DBHDD provides free aids and services to people with disabilities to communicate effectively with us, such as: Qualified Sign Language Interpreters; and written information in other formats (large print, audio, accessible electronic formats, other formats). DBHDD provides free language services to people whose primary language is not English, such as: Qualified Interpreters; and information written in other languages. If you need these services, contact Constituent Services at 404-657-5964 or 888-785-6954.*

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| **ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (404.657.5964 or 888.785.6954)** |
| **ध्यान द�: य�द आप �हंद� बोलते ह� तो आपके लए मफ़ु त म� भाषा सहायता सेवाएं उपलब्ध ह�। (404.657.5964 or 888.785.6954)** |
| **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 or 888.785.6954)** |
| **ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (404.657.5964 or 888.785.6954)** |
| **주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로이용하실 수 있습니다. (404.657.5964 or 888.785.6954) 번으로 전화해 주십시오.** |
| **ВНИМАНИЕ: Если вы говорите на русском языке, то вамдоступны бесплатные услуги перевода. Звоните (404.657.5964 or 888.785.6954).** |
| **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 or 888.785.6954).** |

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| ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. برقم اتصل404.657.5964) or (888.785.6954 |
| ધ્યુ ના: જો તમે ધ્જુ રાતી બોલતા હો, તો ુ ન:ધ્લ્ક ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છે. ફોન કરો (404.657.5964 or 888.785.6954). |
| ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para (404.657.5964 or 888.785.6954). |
| ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (404.657.5964 or 888.785.6954). |
| توجه :اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما با .باشد می 888.785.6954) or (404.657.5964 فراهم |
| ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎትተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ (404.657.5964 or 888.785.6954) |
| ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (404.657.5964 or 888.785.6954) |
| 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 or 888.785.6954)まで、お電話にてご連絡ください。 |