GEORGIA DEPARTMENT OF PUBLIC HEALTH

CCBoH
Clayton County
Board Of Health
PREVENT PROMOTE PROTECT

1117 Battlecreek Road, Jonesboro, GA 30236
Phone: (678) 610-7696 Fax: (770) 603-4023

NAME OF INDVIDUAL/CONSUMER/PATIENT APPLICANT
DATE OF BIRTH
If Known:
Patient Medical Record # Patient SSN#

AUTHORIZATION TO RELEASE 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 the my authorization will remain in effect for (**PLEASE CHECK ONE**)*

- ☐ *Ninety (90) days unless I specify an earlier expiration date here _____*
- ☐ *One (1) year*
- ☐ *The period necessary to complete all transactions on matters related to service provided to me.*

I understand that unless otherwise limited by State or Federal regulations, 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)

_____ _____
(Date) (Signature of Parent or other legally Authorized Representative, where applicable)

_____ _____
(Signature of Witness) (Title or Relationship to Individual)

USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN

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