



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)

To: _____
(Address) (Phone/Fax)

(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 _____

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 **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)
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/Employee or Staff/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 Child ☐ 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 Office of Legal Services at 200 Piedmont Avenue S.E., Suite 510-6, West Tower, Atlanta, GA 30334-9026.

Date this authorization is revoked

Time am/pm

Signature of Individual or Legally Authorized Representative



DBHDD

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 or 888-785-6954.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (404.657.5964 or 888.785.6954)

ਧ੍ਯ ਨ ਦਯ: ਯਯਦ ਆਪ ਯਯਦਯ ਬੋਲਤੁ ਹਯ ਤ੍ਯੋਯੋਯੋ ਆਪਕ ਯਯਲਯ ਮ੍ਯ ਤ ਮਯ ਭ ਯ ਸਹ੍ਯਤ
ਸ ਯ ਯ

उपलब्ध हय।

(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 무료로 이용하실 수 있습니다.

(404.657.5964 or 888.785.6954) 번으로 전화해주시요.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны 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).

ملحوظة: إذا كنت تتحدث أذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. برقم

اتصل (404.657.5964 or 888.785.6954)

ਯੁ ਨਾ: જો તમે યુ રાતી બોલતા હો, તો િો ન: યુ ભાષા સહાય સેવાઓ તમારા માટે 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 فراهم (404.657.5964 or 888.785.6954)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገኙት ይቻላል፡ 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。