



Public Health

District 2

Gainesville, GA

Name of Individual / Consumer / Patient / Applicant	
Date of Birth	
Computer Number	Chart number

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby request and authorize:

_____ (Name of person or agency requesting information)

_____ (Address)

To obtain from:

_____ (Name of person or agency holding information)

_____ (Address)

Portion of Medical Record to be released:

() Entire medical record (this includes specific permission to release all records and other information regarding: psychological notes, drug or alcohol abuse notes, AIDS and other STD related information, all laboratory and x-ray reports, consultation reports, and other outpatient reports).

() Other (details) : _____

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 that my authorization will remain in effect for: (Please Check One)

Ninety (90) days unless I specify an earlier expiration date here: _____

(Date)

One (1) Year

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 withdraw this authorization at any time.

_____ (Date)

_____ (Signature of Individual / Consumer / Patient / Applicant)

_____ (Signature of Witness)

_____ (Title or relationship to individual)

_____ (Signature of parent or other legally authorized representative, where applicable) (Date)

USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN

(Date this authorization is revoked by individual)	(Signature of individual or legally authorized representative)
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