

Georgia Community Support and Solutions

1945 Cliff Valley Way, STE 220, Atlanta GA 30329
(404) 634-4222

Authorization for Use or Disclosure of Protected Health Information

I, _____, authorize the Georgia Department of Human Resources, Division of Mental Health, Development Disabilities and Addictive Diseases provider Georgia Community Support and its administrative and support staff to:

(Check all that apply):

_____ use the following protected health information
_____ disclose the following protected health information to:

The protected health information authorized to be used or disclosed includes:

_____ I authorize the disclosure of alcohol and drug abuse information, (if Any).
_____ I authorize the disclosure of any information concerning testing for HIV(human immunodeficiency virus) and/or treatment for HIV or AIDS (acquired immune deficiency syndrome) and any related conditions, (if any).

The protected health information authorized to be used or disclosed for the following purposes:

The authorization shall be in force and effect Either thirty (30) days after I no longer receive services from this Department of Human Resources provider, or for one year from the date this is signed, whichever is shorter, at which time this authorization expires. I understand that I have the right to revoke the authorization, in writing, at any time by sending such written notification to the:

Department's Privacy Officer:

404.656.4421.Phone/404.657.1123 Fax
2 Peachtree Street, NW
Room 22.240
Atlanta, GA 30303-3142

OR

Divisions Privacy Coordinator

404.657.6423 Phone/404.657.6424 Fax
2 Peachtree Street, NW
Room 29.210
Atlanta, GA 30303-3142

Or to the Staff of my service provider.

The Department of Human Resources and its provider will not condition my treatment, payment, or eligibility for any applicable benefits on whether I provide authorization for the requested use or disclosure.

Signature of Person or
(Person Legally Authorized to sign on his/her behalf.)

/ /
Date

Signature of Witness/Title
Date

Description of Legally Authorized Person's Authority

(Use this space only if individual/resident withdraws authorization)

Date Authorization is withdrawn

Signature of Individual/Resident

Created: